U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 08 May 2007

Case No.: 2006-BLA-05456

IN THE MATTER OF:

E.M.,
Claimant,

v.

PARIS MEADOWS COAL CO., INC.,
Employer,

and

SUN COAL COMPANY, INC.,
Carrier,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES:

Joseph E. Wolfe, Esq.
Wolfe Williams & Rutherford
For Claimant

Russell Vern Presley, II, Esq.
Street Law Firm, LLP
For Employer

BEFORE: Alan L. Bergstrom
Administrative Law Judge

DECISION AND ORDER – GRANTING BENEFITS

This case arises from a claim for benefits filed under the "Black Lung Benefits Act," Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, at 30 U.S.C.

§ 901 *et seq.* ("Act"), and the implementing regulations at 20 C.F.R. Parts 718 and 725 (2006).[1] On September 29, 2006, a hearing was held in Roanoke, Virginia. Accordingly, the decision in this matter is based upon the testimony of Claimant at the hearing,[2] all documentary evidence admitted into the record at the hearing, all documentary evidence permitted by this Administrative Law Judge at the hearing to be submitted post-hearing, and the post-hearing arguments of the parties. The documentary evidence admitted at the hearing includes Director's Exhibits ("DX") 1 through 52, Claimant's Exhibits ("CX") 1 through 3, Employer's Exhibits ("EX") 1 through 3, and Administrative Law Judge's Exhibits ("ALJX") 1 through 6. Post-hearing evidence admitted into the record includes Employer's Exhibits 4 through 6.

Overview

The Black Lung Benefits Act is designed to compensate those miners who have acquired pneumoconiosis, commonly referred to as "black lung disease," while working in the Nation's coal mines. Those miners who have worked in or around mines and have inhaled coal mine dust over a period of time, may contract black lung disease. This disease may eventually render the miner totally disabled or contribute to his death.

In this case, because the Claimant filed his current claim more than one year after his last claim for benefits was decided, the Claimant must demonstrate that "one of the applicable conditions of entitlement has changed since the date upon which the order denying [his] prior claim became final." 20 C.F.R. § 725.309(d). The amended regulations specifically state that the "applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based." 20 C.F.R. § 725.309(d)(2).

In the Fourth Circuit, the claimant must "prove, under all of the probative medical evidence of his condition after the prior denial, at least one of the elements previously adjudicated against him. 20 C.F.R. 725.309(d)(3); *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358 (4th Cir. 1996), cert. denied, 519 U.S. 1090 (1997)(emphasis in original). If the claimant successfully establishes that one of the applicable conditions of entitlement has changed since the denial of his prior claim, his subsequent claim includes all the evidence admitted in connection with his prior claim(s) and is reviewed *de novo*. 20 C.F.R. 725.309(d)-(d)(1); *Lisa Lee Mines*, 86 F.3d 1358.

[1] The Secretary of Labor adopted amendments to the regulations implementing the Federal Coal Mine Health and Safety Act of 1969 as set forth in the Federal Register, 65 Fed. Reg. 79,920 (Dec. 20, 2000). These revised regulations became effective on January 19, 2001. *Id.* Accordingly, because Claimant filed his claim on August 30, 2004 (DX 4) the amended regulations are applicable in this case. Moreover, as Claimant last engaged in coal mine employment in the state of Virginia, appellate jurisdiction of this matter lies with the Fourth Circuit Court of Appeals. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989)(en banc).

[2] The transcript from the hearing is cited in this decision as "TR" and by page and line number.

In this case, Claimant filed his claim after April 1, 1980. Therefore, this claim is governed by the regulations at 20 C.F.R. Part 718. Under Part 718, Claimant bears the burden of establishing each of the following elements by a preponderance of the evidence: (1) Claimant has pneumoconiosis; (2) the pneumoconiosis arose out of coal mine employment; (3) Claimant is totally disabled; and (4) the pneumoconiosis contributes to Claimant's total disability. 20 C.F.R. §725.202(d)(2). Failure to establish any one of these elements precludes entitlement to benefits.

Procedural History

On August 30, 2004, Claimant filed a claim for benefits. (DX 4.) Prior to filing this claim, Claimant had filed two other federal claims for benefits.[3] The first claim was filed on February 20, 1991 (DX 1), and the second claim was filed on March 30, 1998 (DX 2).[4] Claimant's first claim was denied by Administrative Law Judge DiNardi on June 2, 1994. (DX 1.) That denial was affirmed by the Benefits Review Board on April 24, 1995. (DX 1.) Claimant's second claim was denied on June 15, 2001 by Administrative Law Judge Tureck and was not thereafter appealed. (DX 2.)

With regard to the current claim, on December 8, 2005, the district director issued his Proposed Decision and Order granting Claimant benefits. (DX 41.) Shortly thereafter, by letter dated December 16, 2005, Employer timely filed its Request for Hearing.[5] (DX 43.) The case was then referred to the Office of Administrative Law Judges for a hearing on March 6, 2006 (DX 49), and thereafter assigned to this office.

By Notice of Hearing and Order issued June 13, 2006, a hearing was scheduled to be held on September 19, 2006, in Roanoke, Virginia. (ALJX 1.) On July 10, 2006, Claimant's counsel filed a motion requesting that the hearing be continued. (ALJ 2.) By Order issued July 24, 2006, this Administrative Law Judge canceled the September 19, 2006 hearing and rescheduled it for September 29, 2006. At the hearing, exhibits were admitted into the record and the Claimant testified. Also at the hearing, this Administrative Law Judge ordered that the record be held open for the submission of post-hearing evidence and briefs. (TR 36:14-21.) Employer was given until October 15, 2006 to submit a copy of Dr. Fino's deposition testimony taken on September 28, 2006, and both parties were given until November 3, 2006 to submit any

[3] Claimant also attempted to file a state claim, which was denied. (TR 31:25-32:3; DX 2 (DX 3 - Form CM-905)) While this Administrative Law Judge notes that the Form CM-905 (DX 9) submitted as part of Claimant's current claim states that he did not file a state claim for benefits, this Administrative Law Judge finds that DX 9 is incorrect in light of Claimant's testimony at the hearing and the Form CM-905 included in Claimant's prior claim.

[4] Several of the Director's and parties' exhibits from Claimant's two prior claims were incorrectly filed. Exhibits that were part of Claimant's second claim were filed under DX 1, while exhibits that were part of Claimant's first claim were filed under DX 2. The placement of these exhibits within the record has been corrected. In this case, for ease of reference, when either DX 1 or DX 2 are cited herein, the exhibit number assigned in the original claim will also be cited. *See infra* note 29. As an additional note, the original Director's Exhibit 9 from Claimant's March 30, 1998 claim (DX 2) is not in the record.

[5] Employer in this case is self-insured through Sun Coal Company, Inc. (*See* DX 28 and 43.) In prior Pre-Hearing Orders, the West Virginia Coal Workers' Pneumoconiosis Fund was improperly named as the carrier in this case.

additional rebuttal or rehabilitative evidence related to the July 1, 2006 chest x-ray. The Parties were given until December 15, 2006 to submit post-hearing briefs.

By letter motion filed November 3, 2006, Employer requested thirty (30) additional days in which to submit rebuttal evidence related to the July 1, 2006 x-ray, which, as of that date, had not yet been received by Employer. On December 4, 2006, Employer filed its Exhibits 4 and 5 with the court.

By letter motion filed December 15, 2006, Employer's counsel requested additional time to file the Employer's post-hearing brief due to delay in receiving the July 1, 2006 chest x-ray. By Order issued December 21, 2006, this Administrative Law Judge granted Employer's motion and gave the parties until January 18, 2007 to file their briefs. On January 16, 2007, Employer timely filed its post-hearing brief with the court. Claimant's counsel filed his brief on February 26, 2007.

Issues Presented for Adjudication

At the hearing the parties agreed that there are eight (8) issues to be decided by this Administrative Law Judge:

1. Whether Claimant timely filed his claim;

2. The length of Claimant's coal mine employment;

3. Whether there has been a change in a condition of entitlement, as required by 20 C.F.R. § 725.309(d), since Claimant's last claim for benefits was denied on June 15, 2001;

4. Whether Claimant has pneumoconiosis;

5. If Claimant has pneumoconiosis, whether the disease arose out of Claimant's coal mine employment;

6. Whether Claimant is totally disabled;

7. If Claimant is totally disabled, whether his disability is secondary to his pneumoconiosis; and

8. Whether the named Respondent is the responsible operator.

(TR 7:25-8:17.)

Findings of Fact and Conclusions of Law

I. Stipulation

At the hearing, the parties stipulated, and this Administrative Law Judge finds, that for purposes of augmentation pursuant to the Act, Claimant has one dependent, his wife. (TR 6:4-19.)

II. Factual Background and Claimant's Testimony at the Hearing

Claimant, who was born on May 22, 1945 (DX 4), first began working as a miner at age fourteen. Between age fourteen and eighteen, Claimant worked outside of the mine. (TR 15:23-16:1.) Thereafter, Claimant worked underground in the mine. (TR 16:2-3, 18:24-23:2.) As a miner, for the first few years, Claimant worked in mines where the conventional mining method was used. (TR 16:4-18:23.) Claimant would load coal by hand, drill using a breast auger, and shoot coal. (TR 16:4-18:23.) When drilling, claimant stated that he would drill seven holes at a time that were approximately ten feet deep. (TR 16:18-22.) Claimant stated that there was a pad on the drill that would go against one's breast and then when drilling, one had to lean into the drill to push and turn it. (TR 17:2-7.) Thereafter Claimant worked in a coal mine that cut coal using the continuous mining method. (TR 21:6-12.) For a period of time, Claimant operated "electric motors" on the track in the haulway and dusted rock by hand. (TR 23:5-10.) At the hearing, Claimant testified that the bags of rock dust weighed between fifty and sixty pounds. (TR 23:19-20.) In Claimant's last position as a miner, Claimant worked as a mine foreman. (TR 21:19-22:7.)

At the hearing, Claimant stated that he last worked as a miner in 1986. (TR 22:8-20.) On September 15, 1986, Claimant injured his back. (TR 29:7-15.) Thereafter, Claimant attempted to return to work, but was unable to perform his normal duties and was fired. (TR 29:16-22.) Claimant testified that he is currently receiving social security benefits in connection with his back injury. (TR 30:25-31:24.) At the hearing, Claimant testified that he had looked over his social security earnings record and that it "pretty well" reflected his employment history.[6] (TR 20:23-21:2.) Claimant also testified at the hearing that "a lot" of the coal companies didn't pay him like they should have. (TR 19:22-24.)

[6] According to Claimant's social security earnings records and Claimant's testimony at the hearing, Claimant worked from January through March and October through December 1964 at McDonald Coal Company; January through March 1964 at Day Coal Company; January through March 1965 at Horn Coal Company; January through June 1965 at L.M. Colley Coal Company; July 1965 through March 1966 at E&C Coal Company; January through March 1968 at Big Hagy Coal Corporation; January through September 1968 at Diamond Jewell Coal Corporation; January 1971 through June 1972 and January 1974 through June 1974 at Island Creek Coal Company; July 1973 through March 1974 and April 1975 through September 1976 at Winston Mining Company; April 1974 through June 1975 at Jewell Ridge Coal Corporation; January through September 1977 and January 1978 through December 1980 at Dominion Coal Corporation; 1980 at Triple W Coal Company, Inc.; 1981 through 1982 at Four D Coal Company, Inc.; 1983 through 1984 at Paris Meadows Coal Company; and 1984 through 1986 at Paris Meadows Coal Company, Inc. (DX 5 and 8; TR 18:24-22-20.)

With regard to his current physical condition, Claimant testified that since 1999, he has been on oxygen every night. (TR 25:10-15.) Claimant also testified that his "breathing" has gotten worse since his last hearing for his prior claim. (TR 26:6-8.) Claimant testified that, due to his breathing problems, he is now unable to hunt deer. (TR 26:9-15.) Claimant stated that he believes his breathing problems began in 1981 and acknowledged that he smoked until July 2006, when he suffered a heart attack. (TR 27:23-28:15.) Claimant testified that he did not have surgery in connection with his heart attack and that he is now currently taking Plavix and aspirin for his heart condition. (TR 32:7-14.) With regard to his smoking habit, Claimant testified that he smoked a pack of cigarettes a day since the age of eighteen and that over the years he had tried to quit smoking "a half dozen times." (TR 35:1-13.)

At the hearing, Claimant testified that he has been treated by a Dr. Forehand for black lung disease since approximately 1999. (TR 32:15-33:15.) Claimant testified that he was first told that he had black lung disease and that he was disabled by a Dr. Modi in connection with his first claim for benefits.[7] (TR 32:24-33:4.) Claimant testified that Dr. Forehand also told him that he had black lung disease and that he was disabled. (TR 33:12-15.) At the hearing, Claimant testified that based on just his breathing problems, he did not feel that he could now work in the mines. (TR 28:16-19.) Claimant stated that with the "jarring and the breathing and dust, there ain't no way I could stand it." (TR 28:20-22.)

III. New Medical Evidence

The medical evidence in this case includes various chest x-rays, pulmonary function studies, arterial blood-gas studies, and physicians' opinions, which are summarized below.

A. Chest X-rays

The following chest X-ray reports are in the record: [8]

Exhibit #/ Submitting Party/Purp.	*Name of Reader*	*Radiological Qualification* [9]	*Date of Study*	*Date of Reading*	*Film Quality*	*Reading*[10]	*Sm. Opacities Shape/Size Prim./Sec.*	*Sm. Opacities Zones*[11]	*Large Opacities*

[7] Dr. Modi is spelled Moadey in the hearing transcript.

[8] Claimant designated an August 2, 1999 reading by Dr. Robinette (DX 2 (CX 4, 6)) as part of his initial evidence. Yet, this x-ray reading cannot be considered by this Administrative Law Judge in determining whether there has been a change in a condition of entitlement because the evidence was submitted as part of Claimant's prior claim. 20 C.F.R. § 725.309(d)(3); *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358 (4th Cir. 1996), cert. denied, 519 U.S. 1090 (1997). In analyzing whether there has been a change in a condition of entitlement, this Administrative Law Judge must accept as correct the earlier denial of benefits and its necessary factual underpinnings. *Lisa Lee Mines*, 86 F.3d at 1361-62. Moreover, this Administrative Law Judge notes that this x-ray reading will be considered as part of a full review of the record if Claimant successfully proves a change in a condition of entitlement, irrespective of its designation by either party with regard to the current claim. See 20 C.F.R. 725.309(d)-(d)(1). Also, Employer in its post-hearing brief noted three x-ray readings which it indicated were part of Claimant's hospitalization and treatment records: a reading by Dr. Antoun of a March 20, 2006 x-ray and readings by Drs. Forehand and Makarewicz of a November 10, 1999 x-ray. (Employer's Br. 4). After thoroughly reviewing the evidence, this Administrative Law Judge finds that these x-ray readings are not in the record.

[9] A"B-reader" ("B") is a physician, but not necessarily a radiologist, who successfully completed an examination in interpreting x-ray studies conducted by, or on behalf of, the Appalachian Laboratory for Occupational Safety and

DX 13 / D / DOL Exam	Dr. Manu Patel	BCR / B	11/3/04	11/4/04	1	1/1	p/s	All	0
DX 14 / D / DOL Exam	Dr. Shiv Navani	BCR / B	11/3/04	1/6/05	2	Quality			
DX 18 / C / Rebuttal[12]	Dr. Michael Alexander	BCR / B	11/3/04	3/7/05	1	1/1	p/s	All	0
DX 16 / E / Rebuttal	Dr. Paul Wheeler	BCR / B	11/3/04	3/29/05	2	Neg.			
DX 20; TR 9:3-7 / E / Initial	Dr. James Castle	B	7/20/05	8/1/05	1	0/1	s/t	R(L), L(L)	0
CX 1 / C / Initial	Dr. Kathleen DePonte	BCR / B	7/1/06	7/5/06	1	1/1	p/s	All	0
EX 5 / E / Rebuttal	Dr. John Scatarige	BCR / B	7/1/06	11/14/06	1	Neg.			

B. Pulmonary Function Studies

In a claim for benefits under the Act, a Claimant must prove that he is totally disabled. One method by which total disability may be established is through a preponderance of qualifying pulmonary function studies. To be qualifying, the regulations provide that the FEV_1 be qualifying *and* either (1) the MVV or FVC values must be equal to or fall below those values listed at Appendix B of 20 C.F.R. Part 718 for a miner of similar gender, age, and height, or (2) the result of the FEV_1 divided by the FVC must be equal to or less that 55 percent. 20 C.F.R. § 718.204(b)(2)(i). The following pulmonary function studies are in the record:

Exhibit #/ Submitting Party	***Physician***	***Date of Test***	***age[13]/ height (in.) coop/comp***	***Tracings/ Flow-Vol. Loop***	***Pre (Post)[14] FEV_1***	***Pre (Post) FVC***	***Pre (Post) MVV***	***Pre (Post) FEV_1/FVC***	***Qualifies?[15]***

Health (ALOSH). 20 C.F.R. § 718.202(a)(ii)(E). A designation of "Board-certified" ("BCR") denotes a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology or the American Osteopathic Association. 20 C.F.R. § 718.202(a)(ii)(C).

[10] A reading of "Neg." indicates that the physician read Claimant's x-ray as completely negative.

[11] "R" represents the right lung and "L" the left lung. "U" represents the upper lung zone, "M" the mid lung zone, and "L" the lower lung zone.

[12] *See Sprague v. Freeman United States Coal Mining Co.*, BRB No. 05-1020 BLA (August 31, 2006) (unpub.) (holding that a positive chest x-ray offered to rebut the positive x-ray interpretation provided in conjunction with the DOL sponsored pulmonary evaluation was rebuttal evidence because it responded to the case presented by the opposing party).

[13] The general consensus among the physicians in this case appears to be that Claimant is approximately sixty-seven inches tall. Accordingly, this Administrative Law Judge finds that Claimant is sixty-seven inches tall.

[14] Pre(Post) refers to data generated before and after a bronchodilator was administered.

[15] The qualifying studies listed in the table qualify based on the FEV_1/FVC ratios obtained in those studies. Additionally, the July 20, 2005, November 24, 1999, and August 18, 2003 studies also qualify under the regulations based on Claimant's FEV_1 and MVV values: yet in this case, Claimant may not prove total disability pursuant to 20 C.F.R. § 718.204(b)(2)(i) based on these values because the documentation of the MVV values do not substantially

DX 19 at 33, CX 2 at 42 / C*	Dr. J. Randolph Forehand	11/24/99	54 / 67 Not noted	Yes / Yes	1.84 (2.11)	3.69 (3.95)	57 (53)	49.86% (53.42%)	Yes (No)
DX 19 at 32, CX 2 at 41 / C*	Dr. J. Randolph Forehand	1/25/00	54 / 67 Not noted	Yes / Yes	2.20	3.61	--	60.94%	No
DX 19 at 31, CX 2 at 40 / C*	Dr. J. Randolph Forehand	8/2/00	55 / 67 Not noted	Yes / Yes	1.70	2.85	--	59.65%	No
DX 19 at 26, CX 2 at 34 / C*	Dr. J. Randolph Forehand	9/12/00	55 / 67 Good effort	Yes / Yes	1.38 (1.61)	2.80 (3.11)	--	49.29% (51.77%)	Yes (Yes)
DX 19 at 30, CX 2 at 39 / C*	Dr. J. Randolph Forehand	3/14/01	55 / 67 Not noted	Yes / Yes	1.95	3.63	--	55.72%	No
DX 19 at 21, CX 2 at 29 / C*	Dr. J. Randolph Forehand	9/21/01	56 / 67 Short of breath during test	Yes / Yes	2.10 (1.92)	3.66 (3.46)	--	57.38% (55.49%)	No (No)
DX 19 at 17, CX 2 at 25 / C*	Dr. J. Randolph Forehand	8/18/03	58 / 67 Not noted	Yes / Yes	1.72 (1.93)	3.14 (3.84)	40 (59)	54.78% (50.26%)	Yes (No)
DX 13 / DOL Exam	Dr. Donald Rasmussen	11/3/04[16]	59 / 66 Good / Good	Yes / Yes	1.83 (1.99)	3.45 (3.75)	--	53.04% (53.07%)	Yes (No)
DX 19 at 13, CX 2 at 20, CX 3 at 33 / C*	Dr. J. Randolph Forehand	2/17/05	59 / 67 Not noted	Yes / Yes	2.25 (2.35)	3.97 (4.35)	71 (76)	56.68% (54.02%)	No (No)
DX 20, EX 3 at 19:14-16 / E, C	Dr. James Castle	7/20/05	60 / 67 Studies valid, good effort	Yes / Yes	1.67 (1.75)	3.06 (3.25)	53	54.58% (53.85%)	Yes (Yes)
CX 2 at 16 / C*	Dr. J. Randolph Forehand	3/20/06	60 / 67 Coop. w/ good effort	No / Yes	1.92 (2.23)	4.10 (4.57)	52 (55)	46.83% (48.80%)	No (No)
CX 2 at 15/ C*	Dr. J. Randolph Forehand	6/20/06	61 / 67 Not noted	No / No	1.97	3.31	--	59.52%	No

*These pulmonary function studies are part of Claimant's hospitalization and treatment records and are admissible pursuant to 20 C.F.R. § 725.414(a)(4).[17] Yet after reviewing these studies, this Administrative Law Judge finds that, with the exception of the August 12, 2000 study, all of the studies either do not have three tracings or do not indicate that Claimant adequately understood or cooperated (gave a good effort) in the test. Accordingly, for the purpose of determining whether Claimant is totally disabled pursuant to 20 C.F.R. § 718.204(b)(2)(i), this Administrative Law Judge finds that the reliability of the foregoing studies is questionable and therefore finds that the foregoing studies should be accorded very little weight in this case.[18]

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comply with the quality standards set forth in 20 C.F.R. § 718.103.

[16] The time of this study is not indicated. The study only indicates that the test was performed in the morning. Although the test does not strictly comply with the quality standards set forth in 20 C.F.R. § 718.203, this Administrative Law Judge finds that the study substantially complies with the regulations and is reliable.

[17] Included in Claimant's CX 2 is a study (pulmonary function and arterial blood-gas) dated March 8, 1991, performed by Dr. Forehand. This study is not admissible pursuant to 20 C.F.R. § 725.414(a)(4) because it is not a hospitalization or treatment record as therein defined because the study is part of the DOL sponsored exam for Claimant's first claim. However, the study is admissible into the record pursuant to 20 C.F.R. § 725.309(d)(1).

[18] This Administrative Law Judge notes that the Benefits Review Board has held that a study that is nonconforming because it does not contain statements regarding a miner's cooperation and comprehension may still be accorded probative value when the study is non-qualifying. *Crapp v. U.S. Steel Corp.*, 6 B.L.R. 1-476 (1983). Yet, under the

C. Arterial Blood-Gas Studies

Another method by which total disability may be established is by qualifying blood-gas studies under 20 C.F.R. § 718.204(b)(2)(ii). To be qualifying, the PO2 values corresponding to the PCO2 values must be equal to or less than those found in the table in Appendix C of 20 C.F.R. Part 718. The following blood gas studies are in the record:

Exhibit # / Submitting Party	*Physician*	*Date of Test*	*Altitude[19] (feet)*	*Resting (Exercise) PCO2*	*Resting (Exercise) PO2*	*Qualifies?*
DX 19 at 34; CX 2 at 43 / C*	Dr. J. Randolph Forehand	11/24/99	0-2999	38 (39)	65 (81)	No (No)
DX 19 at 27; CX 2 at 35 / C*	Dr. J. Randolph Forehand	9/12/00	0-2999	38.0	55.0	Yes
DX 19 at 22; CX 2 at 30 / C*	Dr. J. Randolph Forehand	9/21/01	0-2999	37 (36)	61 (53)	Yes (Yes)
DX 19 at 18; CX 2 at 26 / C*	Dr. J. Randolph Forehand	8/18/03	0-2999	34.0	63.0	Yes
DX 13, 15 / DOL Exam	Dr. Donald Rasmussen	11/3/04	0-2999	37 (35)	73 (58)	No (Yes)
DX 15 / DOL Exam	Dr. John Michos	11/3/04	Test technically acceptable			
DX 19 at 14; CX 2 at 21; CX 3 at 33 / C*	Dr. J. Randolph Forehand	2/17/05	0-2999	39.0	61.0	Yes
DX 20; ALJX 5, 6 / E, C	Dr. James Castle	7/20/05	0-2999	33.9	62.3	Yes
CX at 17 / C*	Dr. J. Randolph Forehand	3/20/06	0-2999	36.0	68.0	No

*These arterial blood-gas studies are part of Claimant's hospitalization and treatment records and are admissible pursuant to 20 C.F.R. § 725.414(a)(4).[20] Moreover, after reviewing these studies, this Administrative Law Judge finds that they are in substantial compliance with the quality standards set forth in 20 C.F.R. § 718.105.[21] Accordingly, this Administrative Law Judge finds

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circumstances of this case, this Administrative Law Judge does not find the studies in which non-qualifying results were obtained to be any more reliable than the studies in which qualifying results were obtained. Notably, in this case, all of the FEV_1/FVC ratios are very close to qualifying. Moreover, while it is true that a better effort on the part of Claimant could only produce higher values, there is no guarantee that Claimant's FEV_1 and FVC values would increase in exactly the same proportion. Thus, this Administrative Law Judge finds that the nonconforming, non-qualifying studies are entitled to no more weight than the nonconforming, qualifying studies in the record.

[19] The altitudes for the studies performed by Dr. Forehand were deduced from Claimant's Evidence Summary Form (ALJX 5) and Dr. Castle's study (DX 20), which, like the studies performed by Dr. Forehand, took place in Richlands, Virginia. This Administrative Law Judge further notes that in a study that was submitted as part of Claimant's first claim (DX 1 (DX 18)), which also was performed in Richlands, Virginia, Dr. Forehand noted the altitude as being between 0-2999 feet.

[20] *See supra* note 17.

[21] This Administrative Law Judge notes that the studies did not include the altitude at which the tests were performed, time between drawing of samples and analysis of samples, and whether equipment was calibrated before and after each test. As per footnote 19, the altitudes for these studies have been deduced. With regard to the remaining missing information, this Administrative Law Judge finds that, in light of the circumstances of this case, the omissions do not affect the reliability or probative value of the studies and therefore further finds that the studies are in substantial compliance with 20 C.F.R. § 718.105.

that these studies are probative evidence of whether Claimant is total disabled pursuant to 20 C.F.R. § 718.204(b)(2)(ii).

D. Medical Opinions

In this case, the medical opinion evidence consists of the opinions of Dr. Rasmussen, who performed the U.S. Department of Labor sponsored pulmonary evaluation, Dr. Castle, and Dr. Fino.

Medical Opinion by Dr. Donald Rasmussen (DX 13)

In a medical report dated November 3, 2004, Dr. Rasmussen summarized his findings regarding his examination of Claimant, which occurred on that same day. (DX 13.) Dr. Rasmussen, who is a B-reader and Board-certified in internal medicine, has been appointed to several committees advising on the topics of the health of coal miners and the federal black lung program. (DX 13.) Currently, Dr. Rasmussen practices pulmonary medicine in West Virginia. (DX 13.) In the past, Dr. Rasmussen served as Assistant Chief, Tuberculosis Section, of Fitzsimmons General Hospital in Denver Colorado, between January 1960 through July 1961; Chief of Chest Service at Brooke General Hospital at Fort Sam in Houston, Texas, between July 1961 through August 1962; Associate Chief of Internal Medicine at Miners Memorial Hospital in Beckley, West Virginia, between November 1962 through January 1964; Chief Medical Officer of the Appalachian Coal Miners Research Coal Unit, between January 1964 through January 1966, and Chief of the Pulmonary Section, between February 1966 through December 1973, at the Appalachian Regional Hospital in Beckley, West Virginia; and Director at the Appalachian Pulmonary Laboratory, Inc., in Beckley, West Virginia, between December 1973 through March 1987. Dr. Rasmussen has also published several papers and articles on the topics of coal workers' pneumoconiosis, smoking, pulmonary impairments, and the effects of a coal miner's occupational exposure and smoking history on pulmonary function study and blood gas study results. (DX 13.)

In his report, Dr. Rasmussen summarized Claimant's employment, family, medical, and social histories. Dr. Rasmussen noted Claimant had a work history of approximately twenty years of coal mine experience and that Claimant's last job with the Employer was as a section foreman which involved "considerable heavy and very heavy manual labor." Dr. Rasmussen also noted that, as of the date of the examination, Claimant, who had begun smoking in 1963, continued to smoke a pack of cigarettes a day.

Regarding Claimant's medical history, in relevant part, Dr. Rasmussen noted that Claimant had pneumonia four times between 1990 and 1993. He also noted that Claimant's current medications then included "Combivent, nebulizer and nocturnal oxygen." With regard to Claimant's then present complaints, Dr. Rasmussen noted that Claimant complained of sputum, wheezing, dyspnea, cough, and chest pain. During the physical exam, Dr. Rasmussen noted that with regard to examination of Claimant's extremities, Claimant had clubbing of +1. With regard to examination of Claimant's thorax and lungs, Dr. Rasmussen noted that Claimant's chest expansion was reduced, breath sounds were very markedly reduced, that there were no rales, rhonchi or wheezes, and that there was a prolonged expiratory phase and coarse wheezing with

forced expirations. With regard to examination of Claimant's heart, Dr. Rasmussen noted that the sounds were markedly reduced.

Elsewhere in his medical report, Dr. Rasmussen summarized the diagnostic testing conducted in conjunction with his physical examination and the results of those tests:

Chest x-ray	Pneumoconiosis p/s 1/1 throughout all lung zones. [Dr. Rasmussen noted in his report that Claimant's x-ray was interpreted by Dr. Patel, who is both a B-reader and a Board-certified radiologist.]
Vent Study (PFS)	Moderate, slightly reversible obstructive ventilatory impairment
Arterial Blood-Gas	Marked impairment of oxygen transfer during light exercise. [Resting blood gases were normal.]
Other	SBDLCO moderately reduced

In the cardiopulmonary diagnosis(es) section of his medical report, Dr. Rasmussen made the following diagnoses: (1) based on x-ray evidence of pneumoconiosis and a twenty year coal mine employment history, Claimant has coal workers' pneumoconiosis ("CWP"); and (2) based on Claimant's chronic productive cough, airflow obstruction and reduced single breath diffusing capacity for carbon monoxide ("SBDLCO"), Claimant has chronic obstructive pulmonary disease ("COPD")/emphysema. In the etiology section of his medical report, Dr. Rasmussen stated that he based his diagnoses on the following causes: (1) CWP caused by coal dust exposure; and (2) COPD/emphysema caused by coal dust exposure and cigarette smoking.

With regard to Claimant's level of impairment, Dr. Rasmussen made the following statements:

> The patient has marked loss of lung function as reflected primarily by his marked impairment in oxygen transfer and hypoxia during light exercise. He also has significant ventilatory limitation. He does not retain the pulmonary capacity to perform his last regular coal mine job.

With regard to the causes of Claimant's impairment, Dr. Rasmussen further stated that:

> The two causes of the patient's impaired function are his cigarette smoking and his coal mine dust exposure. Both cause lung tissue destruction indistinguishable by x-ray exam, physical examination or physiologic measurements and are independent of x-ray abnormalities.

Dr Rasmussen also stated that "[c]oal mine dust exposure also causes impairment in oxygen transfer, which is out of proportion or absent ventilatory impairment as in [Claimant's] case." In support of his causation conclusions, Dr. Rasmussen cited several scientific articles. Dr. Rasmussen concluded his report by stating that Claimant's "coal mine dust exposure is a major contributing factor in [his] disabling lung disease."

Medical Opinion by Dr. James Castle (DX 20, EX 3) [22]

Dr. Castle is a B-reader and Board-certified in internal medicine with a subspecialty in pulmonary disease. (DX 20.) He specializes in pulmonary medicine and his practice deals primarily with pulmonary disease. (EX 3, 6:24-7:3.) Dr. Castle has also been involved in critical and sleep medicine and performs occupational lung examinations for black lung, asbestos, tight building syndromes, occupational asthma, and other lung diseases. (EX 3, 7:3-7.) In the past, Dr. Castle has been involved in performing pharmaceutical research studies. (EX 3, 7:7-8.) From 1975 through 1977, Dr. Castle served as Chief of the Pulmonary Section of the Naval Regional Medical Center in Philadelphia, Pennsylvania. He has also published articles and given presentations on pulmonary disorders such as chronic obstructive pulmonary disease ("COPD") and published articles involving comparisons studies of alveolar tissue in smokers and non-smokers. (DX 20.)

On July 20, 2005, Dr. Castle examined Claimant. His findings are summarized in his report dated September 14, 2005. (DX 20.) In this report, Dr. Castle noted Claimant's family, social, occupational, smoking, and medical histories. With regard to Claimant's occupational history, Dr. Castle noted that Claimant worked in the mines for twenty years and that for the last fourteen to fifteen years, Claimant worked as a mine foreman. Dr. Castle noted that there "was a lot of heavy labor involved in what [Claimant] had to do."

With regard to Claimant's smoking history, Dr. Castle noted that Claimant had approximately a forty-two pack year smoking history. He noted that Claimant began smoking at the age of eighteen and presently continued to smoke a pack of cigarettes a day. With regard to Claimant's medical history, in relevant part, Dr. Castle noted that Claimant had had pneumonia in the past and had no history of heart trouble, asthma, or tuberculosis. Dr. Castle further noted that Claimant complained of "having trouble with shortness of breath and his wind cutting off since about 1981 … a cough for at least three months out of the year productive of some sputum that had been present for about 20 years or so" and wheezing mostly at night or around irritants such as hairsprays and perfumes. Claimant also stated that he would, on occasion, wake up at night short of breath and have to use his inhalers. Dr. Castle also noted that Claimant was currently using a "Combivent inhaler, oxygen eight hours a night, Orudis as needed, and Tylenol."

After physically examining Claimant, Dr. Castle noted that the chest exam revealed a normal AP diameter, Claimant had no intercostal retractions and did not use the accessory muscles with quiet breathing, Claimant had normal percussion and fremitus, breath sounds were present bilaterally and were equal, no rales, crackles, or crepitations were heard, Claimant had bilateral wheezes posteriorly and laterally breathing, and a few scattered rhonchi were overheard anteriorly that improved with deep breathing. The remainder of Claimant's physical examination was unremarkable.

[22] After reviewing Dr. Castle's report, this Administrative Law Judge notes that five of the x-ray reports considered by Dr. Castle are not in the record: x-rays dated 3/12/79, 1/14/80, 10/4/83, report by Dr. Susan Epling with illegible date, and 8/27/85. However, in light of the substantial other evidence relied on by Dr. Castle in rendering his opinions in his report and the fact that the foregoing x-rays appear to pre-date by twenty years, the more recent medical evidence considered by Dr. Castle in rendering his opinions, this Administrative Law Judge does not find that Dr. Castle's report should be accorded any less weight. *See Harris v. Old Ben Coal Co.*, 23 B.L.R. 1-98 (2006).

As part of his examination, in addition to performing a physical examination of Claimant, Dr. Castle also examined the results of a chest x-ray, pulmonary function study, arterial blood-gas study, and electrocardiogram performed on Claimant. After reviewing all the foregoing data, Dr. Castle reached the following conclusions:

1. No evidence of coalworker's pneumoconiosis by physical examination, radiographic evaluation, and physiologic testing.
2. Tobacco smoke induced pulmonary emphysema.
3. Moderate airway obstruction with hyperinflation, gas trapping, and reduction in diffusing capacity secondary to number two.
4. Elevated carboxyhemoglobin level consistent with ongoing tobacco abuse.
5. Abnormal electrocardiogram

In addition to reviewing Claimant's history and the aforementioned test results and physically examining Claimant, Dr. Castle also reviewed other medical data which accounts for almost all of the medical evidence of record submitted as part of all three of Claimant's federal claims. Based on a review of all the foregoing information, Dr. Castle opined that Claimant does not suffer from coal workers' pneumoconiosis. Dr. Castle noted that while Claimant's exposure to coal dust was a risk factor for pulmonary disease, smoking was also a risk factor. Dr. Castle stated that based on Claimant's carboxyhemoglobin level of 9.2%, Claimant was "exposed to probably more than one pack of cigarettes daily." Dr. Castle further noted that Claimant's physical examination presented no indication of the presence of an interstitial pulmonary process: while Claimant had intermittent findings of wheezing and decreased breath sounds, he did not have consistent findings for rales, crackles, or crepitations." Dr. Castle also noted that, while Claimant did have a few increased linear markings in the lower lung zones, these markings were consistent with his rather severe ongoing tobacco abuse. He noted that the "vast majority of radiographic evaluations indicated that [the Claimant] did not have radiographic findings of coalworkers' pneumoconiosis."

Dr. Castle reported that the "current valid physiologic studies have demonstrated evidence of moderate airway obstruction associated with hyperinflation, gas trapping, and reduction in the diffusing capacity" which represent findings indicative of smoke induced pulmonary emphysema. He noted that "when coal workers' pneumoconiosis causes impairment, it generally does so by causing a mixed, irreversible obstructive and restrictive ventilatory defect [and on] some occasions [the Claimant] has demonstrated a mild degree of reversibility which is consistent with tobacco smoke induced pulmonary emphysema." Dr. Castle reported that it is significant that the FEV_1 and FVC values obtained in a pulmonary function study performed by Dr. Sargent on November 27, 1991, some five or more years after Claimant left the mining industry, were normal. Dr. Castle pointed out that during that time, Claimant smoked heavily, which he continued to do as of the date of Dr. Castle's examination.

In his report, Dr. Castle also noted that Claimant's arterial blood-gas studies "have demonstrated a mild degree of hypoxemia at rest with a worsening with exercise." Dr. Castle stated that this "is consistent with [Claimant's] tobacco smoke induced pulmonary emphysema [and that the] fall in the PO2 with exercise is occurring as a result of the reduced diffusing capacity due to [Claimant's] tobacco smoked induced emphysema as well as

ventilation/perfusion mismatching." Dr. Castle opined that, while he found Claimant to be totally and permanently disabled as a result of tobacco smoke induced pulmonary emphysema, he did not find Claimant to be totally and permanently disabled as a result of either coal workers' pneumoconiosis or a coal mine dust induced lung disease. Dr. Castle stated that, even if Claimant did in fact have clinical coal workers' pneumoconiosis, his opinion concerning Claimant's lack of disability as a result of that process would not change because Claimant did not exhibit "physiologic changes indicating disability due to that process."

In a deposition taken on September 11, 2006, Dr. Castle discussed his medical qualifications and his findings as set forth in his medical report. (EX 3.) Dr. Castle also defined pneumoconiosis, both clinical and legal, and noted that it was possible to have the disease without suffering any impairment. (EX 3, 10:3-11:6.) Dr. Castle defined pulmonary emphysema as "a condition in which the lung tissue is destroyed in association with loss of the vascular bed due to a number of different processes, but most prominently due to tobacco smoking." (EX 3, 14:8-11.) With regard to elevated carboxyhemoglobin levels, Dr. Castle stated that a "carboxyhemoglobin is manufactured by carbon monoxide being attached to hemoglobin." (EX 3, 15:7-8.) Dr. Castle explained that "[c]arbon monoxide is a toxic gas that is produced through combustion or incomplete combustion and it is bound by hemoglobin in the bloodstream." (EX 3, 15:8-15.) Dr. Castle further stated that "normally, you would have a level of less than 1.5 percent, and [Claimant's] level was 9.2 percent, which is very strikingly elevated and would be up that high in someone who is smoking probably in excess of one package of cigarettes daily." (EX 3, 15:8-15.)

In his deposition, Dr. Castle also explained that a diffusion capacity study, which is part of a pulmonary function study, "measures the lungs' ability to take up a gas out of the air and get it into the bloodstream." (EX 3, 20:23-21:1.) By measuring the level of carbon monoxide in the bloodstream, one can determine "how well the lung would take up oxygen." (EX 3, 21:1-5.) Dr. Castle testified that the Claimant's current pulmonary function study indicates his diffusion capacity was low, although it was higher than it had been in 1993. (EX 3, 20:21-22:3.) Dr. Castle stated that improvement in the diffusion capacity was not consistent with coal mine dust induced lung disease. (EX 3, 22:4-12.) Dr. Castle also acknowledged that an improvement in the diffusion capacity was also not consistent with smoking induced lung disease and that Claimant's diffusion capacity test in 1993 may not have been "totally valid." (EX 3, 30:18-31:12.) Dr. Castle stated that he did not "believe that if [Claimant's reduced diffusion capacity results] were due to smoking, it would have gotten better at all [because] once you have destroyed lung tissue, it's gone, and that is not going to get better". (EX 3, 31:2-5.) Dr. Castle reported that Claimant's diffusion capacity "could [have been] affected by a number of things, including [Claimant's] efforts and how big a breath he took …" (EX 3, 31:6-7.)

Dr. Castle reported that the Claimant had a ventilation perfusion mismatching problem which means that "the air is going to areas where there is inadequate perfusion or the blood flow is going to areas where there is inadequate ventilation, and that will result in a fall in the oxygen level in the bloodstream and it's made worse with exercise, and that occurs in people that have underlying lung disease such as emphysema and can occur in coal workers' pneumoconiosis, but in this specific case, I believe that the objective data would indicate that it's due to his tobacco

smoke-induced lung disease with severe or moderate obstruction with severe gas trapping and hyperinflation." (EX 3, 22:18-23:5.)

With regard to his actual examination of Claimant, Dr. Castle stated that Claimant's respiratory related complaints of shortness of breath, productive cough, and wheezing were not diagnostic of any particular type of cardiopulmonary condition. (EX 3, 16:7-19.) Dr. Castle further stated that he believed the bilateral wheezes and scattered rhonchi that he noted during Claimant's physical examination were due to Claimant's underlying pulmonary emphysema. (EX 3, 16:20-17:17.) With regard to the linear irregular opacities in both lower lung zones that he observed in Claimant's x-ray, Dr. Castle testified that these "irregular type opacities are quite common in people that have a heavy tobacco smoking history." (EX 3, 18:19-22 and 28:14-23.) Dr. Castle testified that, with regard to opacities caused by coal mine dust exposure, one would expect to see "small, round regular opacities in the upper lung zones," which Dr. Castle did not observe in Claimant's x-ray. (EX 3, 19:1-3.) Dr. Castle explained that where the opacities tend to form (upper lung zones for opacities caused by coal mine dust and lower lung zones for opacities caused by tobacco smoke) had to do with the effect of gravity in the lungs, which causes "the blood flow to go primarily to the lower lung zones and not as much to the upper, whereas the ventilation, on the other hand, will tend to go more in the upper lung zones, so when you inhale particulate matter of the size of that in some of the pneumoconioses, such as CWP, those particles tend to flow with the air to the upper lung zones as opposed to the lower lung zones." (EX 3, 29:10-22.) Dr. Castle continued by stating that in "other types of pneumoconioses, depending again on particle size, such as asbestos, the exact opposite occurs, and they go to the lower lung zones." (EX 3, 29:19-22.) Moreover, Dr. Castle stated that in "people [who] inhale tobacco smoke, the smoke is distributed again to all of those areas, but there is greater blood flow in the lower lung zones, and because of the greater blood flow, there [are] more inflammatory cells in that area, and as a result of that, they tend to develop these linear scar tissue areas there, because of the relationship to the blood flow." (EX 3, 29:23-30:5.) Dr. Castle testified that, over the course of twelve years, he did not notice any significant change in Claimant's chest x-rays. (EX 3, 19:4-8.)

With regard to Claimant's pulmonary impairment, Dr. Castle acknowledged that coal mine dust inhalation could cause a purely obstructive pulmonary impairment and that coal workers' pneumoconiosis could be both latent and progressive. (EX 3, 27:6-12.) Dr. Castle also acknowledged that coal mine dust inhalation "causes a form of emphysema known as focal emphysema, which is part of the pathologic description of coal workers' pneumoconiosis." (EX 3, 27:13-17.) Dr. Castle further stated that "coal mine dust inhalation doesn't typically cause the same type of emphysema that we see with tobacco smoking." (EX 3, 27:18-19.) Dr. Castle stated that coal workers' pneumoconiosis does not generally cause a reduction in the diffusion capacity until there is a high degree of profusion of either p or r type opacities, which is not typical of stage one simple CWP. (EX 3, 33:11-15.) On the other hand, Dr. Castle stated that reduction in the diffusion capacity is typical in tobacco smoke-induced pulmonary emphysema and further stated that Claimant exhibited a "marked degree of gas trapping and hyperinflation which [were] consistent with the degree of obstruction that he ha[d] as well as the diffusion capacity." (EX 3, 33:15-23.)

While Dr. Castle stated that Claimant could suffer damage to his lungs simultaneously from coal mine dust inhalation and tobacco smoke, he further stated that "to get coal mine dust-induced emphysema, one would have to have CWP, and the emphysema that we see … in the minor degrees would not be sufficient in general to cause the degree of abnormality we see here." (EX 3, 34:1-14.) Dr. Castle further stated that if CWP contributed at all to Claimant's disability, "it would be in a certainly extremely minor amount [and] that in this case, he felt he could rule out such a contribution." (EX 3, 34:15-35:2.) Dr. Castle further stated that, after "looking at the evidence in totality," he opined that Claimant did not suffer from legal pneumoconiosis. (EX 3, 24:17-25:18.) Dr. Castle also stated that, from a "physiologic point of view," he could exclude coal mine dust exposure as being a cause of Claimant's respiratory impairment and opined that Claimant would be just as disabled today had he never set foot inside of a coal mine. (EX 3, 32:7-21.)

Medical Opinion by Dr. Gregory Fino (EX 1, 2, 4, and 5) [23]

Dr. Fino, who is a B-reader and Board-certified in internal medicine with a subspecialty in pulmonary disease, has been in practice since 1982. (EX 4, 5:4-5.) Dr. Fino now works in a consulting practice that is limited to "taking care of the sick patients that come into the intensive care unit," most of whom have pulmonary problems. (EX 4, 5:18-22.) For the previous twenty-two years, Dr. Fino operated an outpatient pulmonary practice. (EX 4, 5:23-24.) During the course of his career, Dr. Fino has experience conducting clinical research involving the study and treatment of acute bacterial bronchitis, chronic obstructive pulmonary disease, community acquired pneumonia, acute bacterial exacerbation of chronic bronchitis, and asthma. (EX 2.)

In a report written on September 7, 2006, Dr. Fino summarized his findings and conclusions regarding his review of the medical evidence of record in this case. At the beginning of his report, he noted that in previous reports he had opined that Claimant did not have coal workers' pneumoconiosis and that, while he had noted that Claimant had a moderate, disabling respiratory impairment, that impairment was due to smoking and was unrelated to the inhalation of coal mine dust. After reviewing the additional medical evidence in this case, Dr. Fino stated that nothing he reviewed caused him to change any of his previous opinions. Dr. Fino asserted that "[i]t is possible, with a reasonable degree of medical certainty, to distinguish the effects of cigarette smoking from those of coal mine dust inhalation," and that it was his opinion "in this case that we are dealing with a cigarette smoking related pulmonary condition."

Dr. Fino reviewed several medical studies and text books discussing research involving occupational lung diseases and the pulmonary function of miners and reported that "based on an analysis of the medical literature, it is indeed possible to determine in a given miner whether or not coal mine dust inhalation was a clinically significant contributing factor in impairment or disability." Dr. Fino concluded by opining that he did not believe Claimant had either legal or clinical pneumoconiosis, and that even if he did have either form of the disease, "his disability

[23] *See infra* note 47. This Administrative Law Judge notes that Dr. Fino referenced pharmacy records from Home Prescription Specialists, Inc., dated 2003 through 2006. Yet, the record only contains one such pharmacy record, dated May 10, 2004. (CX 2 at 24.) However, the medical evidence relied on by Dr. Fino contains numerous other descriptions of Claimant's medications for the period 2003 through 2006. Accordingly, this Administrative Law Judge finds that Dr. Fino's report should not be accorded less weight as a result of his apparently nominal reliance on the foregoing data. *See Harris v. Old Ben Coal Co.*, 23 B.L.R. 1-98 (2006).

would still be related to the inhalation of cigarette smoke" and he would still be as disabled today had he never set foot in a coal mine.

In a deposition taken on September 28, 2006, Dr. Fino discussed his medical qualifications and opinions summarized in his September 7, 2006 report. (EX 5.) Prior to this deposition, Dr. Fino reported he had reviewed additional medical records that included Claimant's most recent treatment and hospitalization notes. In his deposition, Dr. Fino defined coal workers' pneumoconiosis as encompassing clinical pneumoconiosis as well as other coal mine dust related lung diseases that "don't require a positive x-ray or even necessarily a positive biopsy for coal workers' pneumoconiosis," and may include chronic obstructive lung disease, chronic bronchitis, and emphysema. (EX 5, 8:619, 9:10-16.) Dr. Fino opined that coal workers' pneumoconiosis can progress in the absence of coal dust exposure, i.e. be latent and progressive, but that such progression was unusual. (EX 5, 18:21-19:2.) In Claimant's case, Dr. Fino stated that he did not believe that Claimant had coal workers' pneumoconiosis that had merely been latent over the years and was now being revealed in the more recent medical evidence. (EX 5, 19:3-7.) He stated that he based this opinion on the fact that he could "document normal lung function [in Claimant] within five or six years of his leaving the mines [and then] document variable obstructions that [would] come and go in terms of getting worse, then not so bad, from the mid-1990s until the present." (EX 5, 19:9-13.) He testified that "[p]rogressive pneumoconiosis is not going to cause a variable obstruction" and opined that the variability [seen on examination] was caused by Claimant's continuing to smoke some twenty years after leaving the mining industry." (EX 5, 19:14-19.) Dr. Fino testified that while the Claimant "has had some progression in his lung disease since the early 1990s, it [was] due to smoking, not coal dust." (EX 5, 19:20-22.)

Dr. Fino also stated that, with regard to Claimant's employment history, fifteen years working in the coal mining industry would be a sufficient period of time for an individual to develop coal workers' pneumoconiosis, although he opined that Claimant did not have the disease. (EX 5, 12:12-20.) With regard to Claimant's level of disability, he testified that, while Claimant was not totally disabled for any type of labor, he could not perform the labor involved in his last mining position and was "disabled from that job." (EX 5, 13:5-9.) Dr. Fino opined that Claimant's totally disabling impairment was secondary to chronic obstructive lung disease, which had a reversible component, a chronic bronchitic component, and an emphysemic component. (EX 5, 13:10-16.)

In his deposition, Dr. Fino testified that Claimant's obstruction was moderate and partially reversible and that coal mine dust exposure could cause obstruction "either by emphysema or chronic airway obstruction and chronic bronchitis [and] that an obstructive defect could be present without a restrictive component. (EX 5, 15:1-11, 17:12-21.) Dr. Fino stated that there was no reason why coal mine dust inhalation and smoking couldn't simultaneously cause emphysema in the same individual. (EX 5, 25:20-23.) Dr. Fino further reported that twenty years of coal mine dust exposure, although "a little bit on the low side" could cause clinically significant emphysema. (EX 5, 25:24-26:3.)

Dr. Fino opined that Claimant's impairment was entirely caused by Claimant's cigarette smoking. (EX 5, 13:17-20.) Dr. Fino stated that, based on the records he reviewed, he found

that Claimant had smoked approximately one pack of cigarettes a day for forty to forty-two years, which was a sufficient period of time for an individual to develop a respiratory impairment. (EX 5, 13:21-14:4.) Dr. Fino further said that it was possible to distinguish between impairments caused by coal mine dust exposure and impairments caused by cigarette smoking "[i]f you have the objective data[, i.e. pulmonary function studies, arterial blood-gas studies, etc.,] over a period of time – especially in this case – and then a familiarity with the medical literature on coal dust and smoking-related conditions." (EX 5, 14:8-20.) Dr. Fino further explained that the medical literature is helpful because it "teaches you about how a particular exposure will affect the lungs, how much it will affect the lungs, and how to assess its impact on the lungs." (EX 5, 14:21-25.)

Dr. Fino testified that if coal mine dust had played a significant role in Claimant's obstructive impairment, i.e. causing the reduction in Claimant's FEV-1, he would have expected Claimant to have abnormal lung function "at or about the time that he left the mines." (EX 5, 26:14-20.) Dr. Fino stated that, in this case, he did not believe that Claimant had inhaled enough coal mine dust or retained enough coal mine dust in his lungs to cause a clinically significant increase in his obstructive impairment "beyond and above what [was] there due to smoking." (EX 5, 28:2-7.) In his deposition, while Dr. Fino acknowledged that the data upon which he relied to determine what role Claimant's coal mine dust exposure played in his current level of impairment, was based on "averages," Dr. Fino further stated that he also considered whether there were "any indicators in this case that [Claimant] would have had more [coal dust related impairment] than the average [miner]." (EX 5, 29:8-30:8.) Dr. Fino testified that individuals with higher than average impairment due to coal mine dust inhalation, pathologically, had more coal mine dust retained in their lungs; radiographically, had more pneumoconiosis seen on the chest x-ray; had longer durations of exposure; and had more time working in coal mines prior to dust regulations. (EX 5, 30:13-23.) In Claimant's case, Dr. Fino opined that, based on the "fact that [Claimant] had normal lung function six to seven years after he left the mines, the fact that he has lung function that waxes and wanes over time, the fact that he continued to smoke through June of 2006, the lack of finding any significant interstitial abnormality on the chest x-ray, [and] the lack of any decrease in lung volumes, Claimant's exposure to coal dust did not result in a level of impairment greater than the averages noted in the studies he had reviewed. (EX 5, 29:17-30:8.)

With regard to Claimant's impairment, Dr. Fino testified that he found Claimant's condition to be partially reversible because there was "an improvement in the FEV-1 by 16 percent." (EX 5, 15:14-15.) He testified that because Claimant's FEV-1 did not get "completely back to normal," there was "a permanent component to his obstruction" that the reversibility in the Claimant's impairment demonstrated that Claimant's condition couldn't be due to coal mine dust. (EX 5, 15:15-19.) Dr. Fino stated that the reversibility "suggest[ed] a smoking-related reversibility because coal mine dust lung diseases are permanent and irreversible and cannot be improved by medication." (EX 5, 15:19-22.) In his deposition, Dr. Fino explained that smoking causes a reversible impairment by causing inflammation which causes narrowing of the breathing tubes. (EX 5, 23:7-24:10.) Dr. Fino explained that until the narrowing of the breathing tubes became permanent through complete scarring in the breathing tubes, "there [could] be some improvement with bronchodilators". (EX 5, 23:10-18.) While Dr. Fino acknowledged that coal dust could cause some inflammation before permanent scarring

occurred, he further stated that he had found nothing in the medical literature demonstrating that the use of bronchodilators resulted in improvement of coal dust related conditions. (EX 5, 25:3-16.)

Dr. Fino testified that the pulmonary function studies he reviewed revealed that Claimant's lung function had fluctuated over the years. (EX 5, 15:23-16:2.) He stated that "this variability in lung function over time certainly [didn't] sound like a coal dust-related condition since coal dust-related conditions are permanent." (EX 5, 16:5-8.) Dr. Fino therefore opined that, even if Claimant had clinical pneumoconiosis, it was not a substantially contributing cause of Claimant's totally disabling respiratory impairment. (EX 5, 21:1-5.) He testified that "at many times, [Claimant was] worse than at other times" and that Claimant has also "had some times where his lung function has been completely normal." (EX 5, 16:4-9.) Dr. Fino pointed out that in 1993 Claimant had a pulmonary function study that revealed no obstruction and was normal and that in 1991, Claimant had a pulmonary function study "that showed a normal MVV of 129 liters per minute or 101 percent of predicted." (EX 5, 15:9-13.) Dr. Fino testified that it appeared that Claimant's lung function was normal for five or six years after he quit working in the mines and that he has since developed a variable, mild to moderate obstruction, "that really does change quite frequently." (EX 5, 16:14-18.) Dr. Fino also stated that based on the pulmonary function studies he reviewed, he found that Claimant's lungs were over-inflated, which he said was consistent with obstruction, and opined this was due to his smoking. (EX 5, 17: 1-8.)

With regard to the arterial blood-gas studies he reviewed, Dr. Fino stated that they revealed Claimant had mild resting hypoxemia, which he defined as a low blood oxygen level, and was due to Claimant's smoking. (EX 5, 18:2-7.) He further attributed Claimant's deterioration in his oxygen tension with exercise, as noted by Dr. Rasmussen, to Claimant's smoking-induced lung disease. (EX 5, 18:8-14.) He also testified that the ventilation profusion mismatching problem, which was noted by some physicians in their studies, and which Dr. Fino stated was "just lung disease that causes hypoxemia, was also due to Claimant's cigarette smoking. (EX 5, 18:15-21.)

E. Hospitalization Records and Treatment Notes

Treatment Notes from Craig Family Medicine (DX 17)

The treatment notes from Craig Family Medicine, written by Dr. Victor Bell, dated April 29, 2003 to December 21, 2004, document Claimant's treatment for a number of ailments, including in relevant part, cough (11/30/04) and acute exacerbation of COPD and pneumoconiosis (undated note). Claimant's treatment notes also document that sometime between October 9, 2003 and October 23, 2003, Claimant reduced his smoking from one pack of cigarettes a day to three quarters of a pack of cigarettes per day and that Claimant has a history of pneumoconiosis (10/9/03) and chronic lung disease (4/29/03). The notes also document that on October 9, 2003, examination of Claimant's chest revealed decreased airflow and increased PA diameter, while examination of Claimant's chest on November 30, 2004, revealed lungs with good breath sounds throughout.

Treatment Notes from The Clinic (DX 19, CX 2)

The treatment notes from The Clinic document Claimant's treatment for his respiratory problems from November 10, 1999 through June 20, 2006.[24] These records include several progress notes written by Dr. J. Randolph Forehand and certified family nurse practitioners Jill Matney and Jennifer Elswick,[25] pulmonary function studies, and arterial blood-gas studies. These records are treatment records admissible under 20 C.F.R. §725.414(a)(4).[26]

The treatment notes document Claimant's treatment for his pulmonary condition. They document that Claimant complained of wheezing (11/10/99; 3/20/06), cough (11/10/99; 1/25/00; 3/20/06), and shortness of breath (11/10/99; 1/25/00; 2/17/05; 3/20/06; 6/20/06) since approximately 1996 (3/20/06) and that Claimant continued to smoke one pack of cigarettes a day (3/14/01; 8/18/03; 2/17/05; 3/20/6; 6/20/06), although the notes indicate that Claimant quit smoking for a short time in late 1999 (11/10/99; 11/24/99) and that around January 25, 2000 Claimant was smoking only half a pack of cigarettes per day (1/25/00). The notes also document that Claimant's medications included using oxygen at night, a nebulizer, inhalers, and cough syrup (11/10/99; 1/25/00; 8/2/00; 9/12/00; 9/21/01; 8/18/03; 2/17/05; 3/20/06; 6/20/06).

Throughout the notes are findings that Claimant suffered from (1) airflow limitation with resting arterial hypoxemia (9/12/00); (2) exercise induced hypoxemia (9/21/01); (3) chronic bronchitis, thought to be secondary to coal workers' pneumoconiosis (3/14/01; 8/18/03; 2/17/05); and (4) airflow limitation with shortness of breath on exertion stemming from coal workers' pneumoconiosis (6/20/06). A note written on November 24, 1999 stated that possible factors of Claimant's chronic airways disease included Claimant's smoking and underground coal mining employment, while another note written on March 20, 2006 documented that a "chest x-ray raise[ed] the suspicion of pneumonia versus chronic bronchitis." Physical examination of Claimant revealed diminished breath sounds (3/14/01; 8/2/00; 8/18/03; 2/17/05; 3/20/06) and no distinct crackles or wheezes (11/10/99; 1/25/00; 3/14/01; 8/2/00; 8/18/03; 2/17/05; 6/20/06), while pulmonary function tests first revealed a mild to moderately severe, partially reversible obstructive ventilatory pattern (11/24/99; 1/25/00; 9/12/00) that was later found to be an irreversible obstructive ventilatory pattern (3/20/06). The notes also document that Claimant was encouraged to exercise (9/12/00), which, at least until March 2001, he did outside when the weather permitted (3/14/01).

Treatment Notes from Carilion Roanoke Memorial Hospital (CX 3)

These treatment notes, dated March 27, 2005 through May 5, 2006, document Claimant's treatment for a number of different ailments. With regard to this case, the notes mention, in

[24] The cover letter attached to Claimant's Exhibit 2 states that the exhibit includes fifty-seven (57) pages of treatment notes. Yet, Claimant's Exhibit 2, as submitted to this court, contains only fifty (50) pages of treatment notes.

[25] The March 20, 2006 progress note was written by Ms. Matney and the February 17, 2005 progress note was written by Ms. Elswick. All other treatment notes were written or reviewed by Dr. Forehand.

[26] The progress notes in the instant case do not assess the miner's level of disability due to a respiratory or pulmonary condition.

relevant part, that Claimant has a past medical history and was assessed to have black lung disease (8/17/05), past medical history of pneumonia (8/17/05), diagnoses of COPD and acute bronchitis on October 26, 2006 (10/26/05), a tobacco smoking history of one pack per day for forty years (8/17/05), and that Claimant has been receiving disability since 1986 for his back problems and COPD (3/27/06).[27] Claimant's Exhibit 3 also includes treatment notes from The Clinic (CX 2) dated February 17, 2005.

IV. Evidence from Claimant's Prior Black Lung Claims

Summarized below is the evidence that was admitted into the records of Claimant's two prior federal claims. This evidence is part of the record for the current claim pursuant to 20 C.F.R. § 725.309(d)(1).[28]

A. Claimant's Testimony

Testimony given July 22, 1993 at the hearing before Judge DiNardi (DX 1 (TR))

At the hearing before Judge DiNardi, with regard to the exertional requirements of his last coal mining job as a mine foreman, Claimant testified that his daily duties included checking the conditions of the mine and checking the mine for methane before the miners went on duty, supervising the miners throughout their shift, and performing the duties of a miner if the miner was absent. (DX 1 (TR 29:9-14).) In his position as a foreman, Claimant stated that he was exposed to mine dust all the time, on a daily basis. (DX 1 (TR 29:18-21).)

With regard to his physical health, Claimant testified that he had had breathing problems since 1981. (DX 1 (TR 29:24-30:1).) He testified that the first physician to inform him that he had a breathing impairment was a Dr. Mitchell in 1985 or 1986. (DX 1 (TR 30:2-7).) Claimant stated that there were times when he was short of breath, coughed, and wheezed. (DX 1 (TR 30:8-13).) Claimant testified that he could not walk up stairs or hills and that he had problems sleeping at night. (DX 1 (TR 31:2-15).)

With regard to his smoking, Claimant testified that he began smoking at the age of eighteen and was smoking a pack of cigarettes a day during his twenties and thirties. (DX 1 (TR 35:8-25.) Claimant further testified that approximately a year to a year and a half before the hearing, he had reduced his smoking to three or four cigarettes a day. (DX 1 (TR 35:11-14, 36:1-3).)

[27] At the hearing, Claimant stated that he didn't know if his social security benefits were for his respiratory problems as well as his back problems. (TR 30:25-31:24.)

[28] Reference in this section to an "exhibit's number in a prior claim" refers to the exhibit/page number assigned to the evidence in either Claimant's first (DX 1 - February 20, 1991) or second (DX 2 - March 30, 1998) claim and will be noted in parentheses following the exhibit number assigned to the prior claim (DX 1 or DX 2) in Claimant's current claim.

Testimony given on January 18, 2001 at the hearing before Judge Tureck (DX 2 (TR))

At the hearing before Judge Tureck, Claimant provided testimony regarding his coal mine employment. (DX 2 (TR 18:1-25:5).) Thereafter, Claimant testified regarding his physical condition at the time of the hearing. He testified that he had breathing problems that prevented him from doing activities such as walking, walking up hills, and going hunting. (DX 2 (TR 25:6-19).) Claimant testified that he could still hunt from his back porch, but that the last time he had been able to hunt by walking and climbing through the mountains was two years before the hearing. (DX 2 (TR 35:4-12).) He also stated that his breathing problems had "gotten quite a bit worse" since he filed for benefits the first time. (DX 2 (TR 29:12-15).) Claimant testified that he did not believe that he could go back to working in the mines because of his trouble breathing. (DX 2 (TR 28:22-29:1).) With regard to his medications, Claimant testified that he was taking pain medications for his back, and using inhalers, cough syrup, and oxygen at night for his pulmonary problems. (DX 2 (TR 33:10-20, 35:24-36:14).) Claimant testified that he had been using inhalers for approximately the last ten years and oxygen at night for the last six or eight months. (DX 2 (TR 35:22-24, 36:15-16).) With regard to his smoking, Claimant testified that he had quit "a couple weeks" before the hearing. (DX 2 (TR 29:2-8, 34:7-9).) At the hearing, Claimant affirmed that he began smoking around 1963 and that he used to smoke one to two packs of cigarettes per day. (DX 2 (TR 34:1-8).)

B. Chest x-rays

The following chest x-ray reports from the past claims are in the record:

Exhibit # (Exhibit # in Prior Claim)	*Name of Reade*	*Radiological Qualification*[29]	*Date of Study*	*Date of Reading*	*Film Quality*	*Reading*[30]
Chest x-rays Submitted as Part of Claimant's February 20, 1991 Claim						
DX 1 (DX 37 and EX 24)	Dr. Scott	BCR, B	9/11/85	1/25/88	1	Neg.
DX 1 (DX 37)	Dr. Saba	Not noted	9/11/85	1/25/88	1	Neg.
DX 1 (DX 37 and EX 24)	Dr. Wheeler	BCR, B	9/11/85	1/25/88	1	No abnorm.
DX 1 (DX 37)	Dr. Felson	B	9/11/85	2/16/88	1	Neg.
DX 1 (DX 33, 37)	Dr. Spitz	BCR, B	9/11/85	2/18/88	1	Neg.
DX 1 (DX 23, 22)	Dr. Milner	BCR	3/8/91	3/8/91	1	0/1, s/t, R/L(L)
DX 1 (DX 21)	Dr. E.N. Sargent	BCR, B	3/8/91	4/1/91	2	No abnorm.
DX 1 (DX 31)	Dr. Wiot	BCR, B	3/8/91	9/9/91	3	Neg.
DX 1 (DX 33)	Dr. Spitz	BCR, B	3/8/91	9/19/91	2	Neg.

[29] Some of the radiological qualifications noted herein by this Administrative Law Judge are different than those found by the Administrative Law Judges who adjudicated Claimant's prior two claims. This Administrative Law Judge notes that he based his findings on his own thorough review of the evidence of record as required by the regulations.

[30] "No abnorm." indicates that the physician read Claimant's x-ray as showing no abnormalities indicative of pneumoconiosis. A reading of "Neg." indicates that the physician read Claimant's x-ray as completely negative. "R" represents the right lung and "L" the left lung. "U" represents the upper lung zone, "M" the mid lung zone, and "L" the lower lung zone.

DX 1 (DX 38)	Dr. J.D. Sargent	B	11/27/91	11/27/91	1	1/2, t/p, all but R(U)
DX 1 (EX 1, 24)	Dr. Wheeler	BCR, B	11/27/91	7/20/92	2	No abnorm.
DX 1 (EX 1, 24); DX 2 (DX 26)	Dr. Scott	BCR, B	11/27/91	7/20/92	2	Neg.
DX 1 (EX 4, 18)	Dr. Castle	B	11/27/91	8/2/92	1	0/1, s/t, R/L(L) & L(M)
DX 1 (EX 4, 5)	Dr. Hippensteel	B	11/27/91	8/4/92	1	0/1, s/t, R/L(L)
DX 1 (EX 4)	Dr. Stewart	B	11/27/91	8/4/92	2	0/1, s/t, R/L(L)
DX 1 (EX 7)	Dr. Robinson	BCR, B	11/27/91	3/18/93	2	No abnorm.
DX 1 (EX 7, 16)	Dr. Duncan	BCR, B	11/27/91	3/18/93	2	No abnorm.
DX 1 (CX 4)	Dr. Myers	Not noted	4/20/93	4/20/93	1	1/0, p/s, all
DX 1 (EX 15, 16)	Dr. Laucks	BCR, B	4/20/93	8/6/93	2	Neg.
DX 1 (EX 15, 16)	Dr. Duncan	BCR, B	4/20 /93	8/9/93	2	Neg.
DX 1 (EX 23, 24; DX 2 (DX 25)	Dr. Wheeler	BCR, B	4/20/93	9/1/93	1	Neg.
DX 1 (EX 23, 24)	Dr. Scott	BCR	4/20/93	9/1/93	2	Neg.
DX 1 (CX 2)	Dr. Sutherland	Not noted[31]	5/12/93	5/12/93	Not noted	2/2, p, all
DX 1 (EX 15, 16)	Dr. Laucks	BCR, B	5/ 12/93	8/6/93	3	Neg.
DX 1 (EX 15, 16)	Dr. Duncan	BCR, B	5/12/93	8/9/93	2	Neg.
DX 1 (EX 23, 24)	Dr. Scott	BCR	5/12/93	9/1/93	3	Neg.
DX 1 (EX 23, 24); DX 2 (DX 25)	Dr. Wheeler	BCR, B	5/12/93	9/1/93	2	Neg.
DX 1 (EX 17); DX 2 (EX 6)	Dr. Castle	B	8/19/93	8/29/93	1	0/1, s/s, R/L(L)
Chest x-rays Submitted as Part of Claimant's March 30, 1998 Claim						
DX 2 (DX 17, 18)	Dr. Patel	BCR, B	4/22/98	4/27/98	1	1/1, p/p, all
DX 2 (DX 16)	Dr. Cole	BCR, B	4/22/98	6/20/98	1	Neg.
DX 2 (DX 15)	Dr. Navani	BCR, B	4/22/98	7/23/98	3	1/0, t/q, R/L(M,L)
DX 2 (DX 26, 28)	Dr. Scott	BCR, B	4/22/98	10/29/98	2	Neg.
DX 2 (DX 27 and EX 2, 13)	Dr. Wheeler	BCR, B	4/22/98	10/31/98	1	Neg.
DX 2 (EX 5, 6, 22)	Dr. Castle	B	11/5/98	11/5/98	1	0/1, s/s, R/L(L) & L(M)
DX 2 (DX 26 and EX 1)	Dr. Scott	BCR, B	11/5/98	3/5/99	2	No abnorm.
DX 2 (EX 1, 2, 13)	Dr. Wheeler	BCR, B	11/5/98	3/12/99	2	No abnorm.
DX 2 (EX 3, 4)	Dr. Wiot	BCR, B	11/5/98	4/6/99	1	No abnorm.
DX 2 (EX 8, 9, 18)	Dr. Shipley	BCR, B	11/5/98	6/5/99	2	No abnorm.
DX 2 (EX 19, 22)	Dr. Fino	B	11/5/98	12/12/00	1	Neg.
DX 2 (CX 3)	Dr. Mullens	Not noted	8/2/99	8/2/99	Not noted	Pulmonary hyperinflation
DX 2 (CX 4, 6)	Dr. Robinette	B	8/2/99	8/16/99	1	1/0, q/q, R/L(M,L)

[31] Dr. Castle, in a deposition take on September 1, 1993 stated that Dr. Sutherland is neither a B-reader nor Board-certified radiologist. (DX 1 (EX 21, 35:1-2).)

DX 2 (EX 2, 12, 13)	Dr. Wheeler	BCR, B	8/2/99	1/28/00	1	No abnorm.
DX 2 (DX 26 and EX 12)	Dr. Scott	BCR, B	8/2/99	1/29/00	1	No abnorm.
DX 2 (EX 19, 22)	Dr. Fino	B	8/2/99	12/12/00	1	Neg.
DX 2 (CX 2)	Dr. DePonte	BCR, B[32]	3/11/00	3/13/00	1	1/0, p/p, all
DX 2 (DX 26 and EX 14)	Dr. Scott	BCR, B	3/11/00	4/7/00	1	Neg.
DX 2 (EX 2, 13, 14)	Dr. Wheeler	BCR, B	3/11/00	4/8/00	1	No abnorm.
DX 2 (EX 4, 15, 16)	Dr. Wiot	BCR, B	3/11/00	8/16/00	1	Neg.
DX 2 (EX 9, 17, 18)	Dr. Shipley	BCR, B	3/11/00	8/27/00	2	Neg.
DX 2 (CX 7)	Dr. Patel	BCR, B	11/20/00	11/22/00	1	1/1, p/p, all
DX 2 (EX 24)	Dr. Wheeler	BCR, B	11/20/00	1/8/01	1	No abnorm.
DX 2 (EX 2, 13, 24)	Dr. Scott	BCR, B	11/20/00	1/8/01	1	Neg.

C. Pulmonary Function Studies

The following pulmonary function studies are in the record:[33]

Exhibit # (Exhibit # in Prior Claim)	***Physician***	***Date of Test***	***Age/Height (in) /Effort***	***Three Tracings***	***FEV_1***	***FVC/ MVV***	***FEV1/ FVC (%)***	***Qualifies?***
Pulmonary Function Studies Submitted as Part of Claimant's February 20, 1991 Claim								
DX 1 (DX 32)	Dr. Mitchell	9/8/86	Mild small airway disease, with some improvement following bronchodilator.					
DX 1 (DX 14)	Dr. Forehand	3/8/91[34]	47 / 67 Good/Good	No	2.39 (2.28)	3.02 (2.60) / 65 (82)	79.14% (87.69%)	No (No)
DX 1 (DX 34)	Dr. Rosenbloom	5/2/91	45 / 67 Good effort	No	2.71 (2.97)	3.91 (4.40) / 99.9 (129.4)	69.31% (67.50%)	No (No)
DX 1 (DX 38)	Dr. J.D. Sargent	11/27/91[35]	46 / 66 Less than optimal effort	Yes	2.62 (3.06)	2.94 (3.60) / 113 (--)	89.12% (85.00%)	No (No)
DX 1 (CX 4)	Dr. Myers[36]	4/20/93[37]	47 / 66.9 Coop good, FVC valid, FEV_1 invalid	Yes	2.74 (--)	3.71 (--) / --	73.85% (--)	No

[32] There is no objective evidence in the record demonstrating that Dr. DePonte was a B-reader when she read the March 11, 2000, x-ray other than Claimant's counsel's statement designating Dr. DePonte as a B-reader at the hearing for Claimant's second claim. (DX 2 (TR 12:23-24).) Employer's counsel in its brief notes that Dr. DePonte was a B-reader at the time she read the March 11, 2000 x-ray. (Employer's Br. 7.) Accordingly, this Administrative Law Judge finds that Dr. DePonte was a B-reader when she read Claimant's March 11, 2000 x-ray.

[33] The table lists pre / post bronchodilator values for FEV_1, FVC, MVV, and FEV_1/FVC ratio.

[34] Study invalid – Dr. Hippensteel (DX 1 (EX 5)), Dr. Castle (DX 1 (EX 17)); Pre-bronchodilator values nonconforming (post-bronchodilator values not noted) – Dr. Fino (DX 1 (EX 19)); Less than optimal degree of effort – Dr. Sargent (DX 1 (EX 2)).

[35] Pre-bronchodilator values invalid – Dr. Castle (DX 1 (EX 17)), Dr. Fino (DX 1 (EX 19))

[36] Based on a review of the hearing transcript of Claimant's first claim, there was confusion over what documents were actually part of CX 4 and what documents were part of CX 5. The hearing transcript reflects that there was no pulmonary function study by Dr. Myers submitted by Claimant. Yet, upon review of the record, it appears that

DX 1 (CX 5)	Dr. Modi	7/13/93[38]	48 / 67 Prob. Norm. Spirometry, likely poor initial effort	Yes	2.01 (2.04)	2.70 (2.24) / --	74.44% (91.07%)	No (Yes by FVC)
DX 1 (EX 17)	Dr. Castle	8/19/93	48 / 67 Good effort	Yes	2.23 (2.73)	3.42 (4.01) / 74 (87)[39]	65.20% (68.08%)	No (No)
Pulmonary Function Studies Submitted as Part of Claimant's March 30, 1998 Claim								
DX 2 (DX 11, 13)	Dr. Rasmussen	4/22/98	52 / 67 Good	Yes	2.58 (--)	4.36 (--) / 83 (--)	59.17% (--)	No
DX 2 (EX 5)	Dr. Castle	11/5/98	53 / 66 Studies valid	Yes	2.25 (2.35)	4.09 (4.21) / 56.2 (66.1)	55.01% (55.82%)	No (No)
DX 2 (CX 5)	Dr. Robinette	8/2/99	54 / 66 Not noted	No	1.90 (1.80)	3.36 (3.31) / --	56.55% (54.38%)	No (Yes by %)
DX 2 (CX 1)	Dr. Forehand	9/12/00	55 / 67 Good effort	Yes	1.38 (1.61)	2.80 (3.11) / --	49.29% (51.77%)	Yes by % (Yes by %)
DX 2 (CX 7)	Dr. Rasmussen	11/20/00	55 / 66 Not noted	Yes	1.70 (1.91)	3.49 (3.74) / 50 (60)	48.71% (51.07%)	Yes by % (Yes by %)

D. Arterial Blood-Gas Studies

The following blood gas studies are in the record:

Exhibit #	*Physician*	*Date of Test*	*Altitude[40] (feet)*	*Resting Exercise*	*PCO2*	*PO2*	*Qualifies?*
Arterial Blood-Gas Studies Submitted as Part of Claimant's February 20, 1991 Claim							
DX 1 (DX 32)	Dr. Mitchell	9/8/86	Not noted	Not noted	36	76	No
DX 1 (DX 18)	Dr. Forehand	3/8/91	0-2999	R (E)	33 (28)	64 (76)	Yes (No)
DX 1 (DX 19)	Dr. Lantos	3/8/91	Test technically acceptable				
DX 1 (DX 38)	Dr. J.D. Sargent	11/27/91	Not noted	R	38.2	76.7	No
DX 1 (CX 5)	Dr. Modi	7/13/93	Not noted	R	36	73	No
DX 1 (EX 17)	Dr. Castle	8/19/93	Not noted	R	37	70	No
Arterial Blood-Gas Studies Submitted as Part of Claimant's March 30, 1998 Claim							
DX 2 (DX 11, 13)	Dr. Rasmussen	4/22/98	0-2999	R (E)	37 (35)	62 (61)	Yes (Yes)
DX 2 (DX 14)	Dr. Michos	4/22/98	Test technically acceptable				
DX 2 (EX 5)	Dr. Castle	11/5/98	Not noted	R[41]	39	67	No

Claimant did submit a study by Dr. Myers, which was correctly labeled in the record as part of CX 4.

[37] Study invalid – Dr. Renn (DX 1 (EX 12)), Dr. Hippensteel (DX 1 (EX 20)).

[38] Study invalid – Dr. Renn (DX 1 (EX 13)), Dr. Castle (DX 1 (EX 21, 29:4-9)), Dr. Hippensteel (DX 1 (EX 20)), Dr. Sargent (DX 1 (EX 22)); Pre-bronchodilator values invalid (post-bronchodilator values not noted) – Dr. Fino (DX 1 (EX 19)).

[39] In his medical report dated August 19, 1993, Dr. Castle wrote that the "MVV was not valid because of less than maximal effort on the part of the patient."

[40] The values obtained in all of the studies for which the altitude was not noted and could not be deduced based on evidence of record were non-qualifying under all of the altitudes listed in Appendix C of 20 C.F.R. Part 718.

DX 2 (CX 5)	Dr. Robinette	8/2/99	Not noted	R	36.7	68	No
DX 2 (CX 1); DX 1 (DX 18)	Dr. Forehand[42]	9/12/00	0-2999	R	38	55	Yes
DX 2 (CX 7; DX 13)	Dr. Rasmussen	11/20/00	0-2999	R (E)	37 (35)	66 (60)	No (Yes)

E. Medical Opinions

Medical Opinions Submitted as Part of Claimant's February 20, 1991 Claim

Dr. J. Randolph Forehand (DX 1 (DX 15, 16, 17))

Dr. Forehand, whose qualifications are unknown, examined and wrote a medical report regarding Claimant on March 8, 1991. (DX 1 (DX 15)) As part of his examination, Dr. Forehand reviewed Claimant's employment, family, social/smoking, and medical histories. Notably, Dr. Forehand wrote that Claimant, who began smoking in 1965, then currently smoked between one pack to seventy-five cigarettes per day. Dr. Forehand also noted that he had reviewed Claimant's Employment History, Form CM 911a, and wrote in his report that Claimant's last coal mine employment position was as a foreman. He further noted that Claimant had subjective symptoms of sputum, wheezing, dyspnea, cough, and orthopnea. Dr. Forehand also noted Claimant's then current medications, physically examined Claimant (unremarkable), took a chest x-ray (0/1), and performed a pulmonary function study (irreversible COPD), arterial blood-gas study (improved with exercise), and electrocardiogram (normal).

Thereafter, Dr. Forehand opined, based on Claimant's history, physical examination, and the pulmonary function study, that Claimant suffered from irreversible chronic obstructive pulmonary disease ("COPD"), and that, based on Claimant's history of coal dust exposure and chest x-ray, Claimant had coal workers' pneumoconiosis ("CWP"). Dr. Forehand opined that the causes of the foregoing were exposure to coal dust and smoking. Dr. Forehand further opined that "this degree of airway obstruction may result in shortness of breath with lifting or climbing, but without hypoxemia in the absence of exertion, [Claimant] should be able to perform his job." Dr. Forehand concluded by stating that Claimant's COPD and CWP were "the contributing factors to his degree of impairment."

On May 28, 1991, the DOL claims examiner wrote a letter to Dr. Forehand and requested his opinion regarding whether Claimant suffered from legal pneumoconiosis in light of the fact that Claimant's x-ray was read and reread as negative, the pulmonary function study values were non-qualifying and the arterial blood-gas values were qualifying. (DX 1 (DX 16)) In a letter dated June 28, 1991, (DX 1 (DX 17)) Dr. Forehand responded that although Claimant's ventilatory values exceeded disability standards, Claimant exhibited impairment due to chronic airflow obstruction and, while his chest x-ray revealed no evidence of significant coal dust accumulation, "this diagnostic modality would not be expected to elucidate the other respiratory

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[41] Exercise portion declined by Claimant because of back and hip pain.

[42] Employer does not list Dr. Forehand's study in its post-hearing brief, yet the study was admitted into the record by Judge Tureck (DX 2 (TR 12:4-14:22)) and therefore is part of the record for the current claim pursuant to 20 C.F.R. § 725.309(d)(1).

disorders that are consequent to the chronic exposure to coal dust such as bronchitis and bronchial hyperreactivity (also causes of chronic airflow obstruction)." Dr. Forehand noted that while "the effect of cigarette smoking and dust exposure are not easily distinguished" and "the pattern of awarding disability favors the coal miner who smokes … one can not ignore the substantial body of information that indicates that chronic exposure to coal dust in either smoking or nonsmoking miners causes an accelerated decline in pulmonary function, even after the exposure has ceased." Dr. Forehand opined that although Claimant had no radiographic evidence of black lung disease, his "chronic exposure to coal dust contributed, in part, to his resultant pulmonary impairment."

Dr. J. Dale Sargent (DX 1 (DX 38 and EX 2, 3, 22))

Dr. Sargent, who is Board-certified in internal medicine with a subspecialty in pulmonary disease (DX 1 (EX 2)),[43] examined Claimant on November 27, 1991. His findings are summarized in a medical report written on that same day (DX 1 (DX 38)). Dr. Sargent's examination included Claimant's occupational history (20 years working in underground coal mines), medical history (shortness of breath on exertion, wheezing, chronic productive cough, and some sharp chest pain), family history, social history (then currently smoking three to four cigarettes per day, but in the past smoked one pack per day for twenty years), review of systems, physical examination (lungs clear to auscultation and percussion; coughing with rather deep breathing), a chest x-ray (1/2, t/p), pulmonary function study (post-bronchodilator spirometry normal, mild air trapping indicated, and diffusion capacity slightly diminished which is probably accounted for by Claimant's carboxyhemoglobin level of 11%), arterial blood-gas study, and electrocardiogram.

Based on the foregoing data, Dr. Sargent opined that Claimant had simple coal workers' pneumoconiosis, but that Claimant did not suffer from a ventilatory impairment. Dr Sargent noted that if Claimant did suffer "from any ventilatory impairment, it would be a very mild obstructive impairment" which Dr. Sargent opined was caused by Claimant's cigarette smoking. Dr. Sargent noted that there "was a slight increase in the residual volume consistent with his cigarette smoking history" and that while Claimant's diffusion capacity was diminished, "elevated carboxyhemoglobin levels can depress diffusion capacity" which he believed explained most of the abnormality in this case. Thereafter, Dr. Sargent noted that Claimant "unequivocally ha[d] no restriction," and that "when coal worker's pneumoconiosis causes a ventilatory impairment it causes a mixed obstructive and restrictive pattern." Dr. Sargent concluded his report by opining that Claimant was not disabled from doing his last job as a mine foreman.

In a supplemental report dated July 20, 1992, Dr. Sargent reviewed several chest x-ray interpretations, pulmonary function studies, arterial blood-gas studies, physical examinations, and other medical data admitted as evidence in Claimant's first claim. (DX 1 (EX 2).) After reviewing this data, Dr. Sargent still believed that Claimant had coal workers' pneumoconiosis

[43] Dr. Sargent has research experience dealing with involvement of the lung in patients with polymyositis and migration of neutrophils across tracheal epithelium. He also had one article published regarding the topic of pulmonary vasculitis complicating ulcerative colitis and one on the topic of whether an aggressive diagnostic approach was indicated in viral pneumonitis in a compromised host.

but acknowledged that it was questionable whether Claimant did in fact have the disease, in light of the interpretations of several other physicians. Dr. Sargent also opined that Claimant suffered from a mild obstructive ventilatory impairment caused by Claimant's cigarette smoking. Dr. Sargent noted that Claimant's impairment was purely obstructive and was responsive to bronchodilators. Dr. Sargent found that this impairment was "of the type known to be caused by cigarette smoking and was not of the type known to be caused by coal dust exposure." Dr. Sargent also noted that coal workers' pneumoconiosis of a low profusion, such as he observed when he read Claimant's November 27, 1991 x-ray, "rarely cause[d] a ventilatory defect." Dr. Sargent continued to believe that Claimant was not disabled from working as a coal miner.

In another supplemental report dated August 3, 1992, Dr. Sargent reviewed the x-ray readings of Drs. Wheeler and Scott of Claimant's November 27, 1991 x-ray. (DX 1 (EX 3).) Dr. Sargent stated that the additional information obtained from those readings did "not substantially change [his] opinion, as put forth in [his] independent medical review of July 20, 1992."

In a final supplemental report dated August 31, 1993, Dr. Sargent again reviewed several medical documents, including chest x-rays, pulmonary function studies, arterial blood-gas studies, reports of physical examination, and other medical data. (DX 1 (EX 22).) Thereafter, Dr. Sargent again stated that his opinions remained "basically unchanged," notwithstanding the additional medical data he reviewed.

Dr. Myers (DX 1 (CX 4))

On April 20, 1993, Dr. Myers, whose qualifications are unknown, examined Claimant. His findings are summarized in a report written on that same day. (DX 1 (CX 4)) In his examination, Dr. Myers reviewed Claimant's employment, social, family, and medical histories. Dr. Myers noted that Claimant, who was then smoking a quarter of a pack of cigarettes a day, had previously smoked approximately one pack per day for twenty-nine years. Dr. Myers also noted that Claimant had worked as a miner for twenty to twenty-five years. As part of his examination, Dr. Myers also reviewed Claimant's medications, subjective complaints (increased shortness of breath and chest pain associated with walking), physically examined Claimant (breath sounds normal, occasional wheezes noted), reviewed Claimant's x-rays (1/0, p/s, all lung zones), and performed an electrocardiogram, pulmonary function study (mild restrictive defect in ventilation only), and arterial blood-gas study (slight diminution in pO2).

Based on the foregoing, Dr. Myers diagnosed Claimant with coal workers' pneumoconiosis and chronic obstructive pulmonary disease. Dr. Myers further noted that Claimant's condition was "associated with mild restrictive and obstructive defects in ventilation and slight decrease in pO2, Class II under the AMA guidelines." Dr. Myers concluded that Claimant's "silicosis [was] secondary to his entire history of coal and rock dust exposure and [was] permanent.

Dr. James Castle (DX 1 (EX 4, 17, 18, 21))

Dr. Castle, who is Board-certified in internal medicine with a subspecialty in pulmonary disease (DX 1 (EX 4, 18)), examined Claimant and thereafter summarized his findings in a medical report on August 19, 1993 (DX 1 (EX 17)). As part of his examination, Dr. Castle reviewed Claimant's employment, family, medical, and social histories. Dr. Castle noted that Claimant worked as a miner from the age of eighteen until 1986 and that Claimant's last job was as a mine foreman, which required intermittent heavy labor. Dr. Castle also noted that Claimant was then currently smoking one fourth of a pack of cigarettes a day and, overall, had approximately a twenty-nine pack-year smoking history.

Also as part of his examination, Dr. Castle noted Claimant's medications (inhalers), physically examined Claimant (unremarkable), read Claimant's chest x-ray (0/1, s/s, both lower lung zones), and performed a pulmonary function study (mild obstructive airways disease with very marked response to bronchodilators), arterial blood-gas study, and electrocardiogram. Based on the foregoing data, Dr. Castle concluded that there was no clinical evidence of coal workers' pneumoconiosis and that Claimant suffered from mild chronic obstructive pulmonary disease, consisting primarily of "asthmatic bronchitis related to Claimant's long history of cigarette smoking." He opined that Claimant did not suffer from coal workers' pneumoconiosis and was not permanently and totally disabled as a result of that disease.

Thereafter, Dr. Castle reviewed several medical documents, which included chest x-ray interpretations, pulmonary function studies, arterial blood-gas studies, reports of physical examination, and other medical data. Based on all the foregoing information, Dr. Castle opined that Claimant did not have coal workers' pneumoconiosis. He further opined that while Claimant had a mild obstructive ventilatory defect, it was totally reversible, was related to Claimant's smoking habit, and did not prevent Claimant from performing his usual coal mining employment duties, i.e. was not totally disabling.

In a deposition taken on September 1, 1993 (DX 1 (EX 21)), Dr. Castle discussed his medical qualifications and opinions as set forth in his August 19, 1993 medical report. In his deposition, Dr. Castle also defined coal workers' pneumoconiosis and described how the disease is diagnosed:

> Coal worker's [sic] pneumoconiosis is an inhalational dust disease of the lungs that may be contracted in a susceptible person by being exposed to adequate amounts of coal dust. . . .
>
> Medically, the disease is characterized by a patient who may have no symptoms whatsoever. They may only have an abnormal chest x-ray, which may be characterized by the presence of small round regular opacities usually starting in the upper lung zones and at higher levels of profusion may progress to involve the lower lung zones. This is what we describe as the radiographic appearance of simple coal worker's [sic] pneumoconiosis. Patients that have that stage of disease may have no symptoms whatsoever. But when they do become clinically significant, they usually have some shortness of breath, and by physical

> examination they will demonstrate the presence of crackles or rales in their lungs to auscultation. At that time they may have, again, normal pulmonary function studies.
>
> When they do have clinical problems with it, they will develop what's called a restrictive ventilatory process, and by that I mean that they will develop a reduction in the total lung capacity, which may also result in a reduction in their forced vital capacity. They may develop some mild degree of hypoxemia, and since coal worker's [sic] pneumoconiosis is an irreversible process, that hypoxemia generally doesn't improve and does not improve with exercise. . . .
>
> As far as the treatment is concerned, by and large, there isn't any specific treatment for coal worker's [sic] pneumoconiosis in that it's an irreversible dust disease that results from the deposition of this material in the interstitium of the lungs. There's no way to remove that.
>
> We treat the patient symptomatically. For example, if they develop a clinical bronchitis, as anybody else might develop, we would treat them symptomatically for that.

(DX 1(EX 21, 6:22-8:20))

Thereafter, in his deposition, Dr. Castle reviewed Claimant's employment history and stated that he found Claimant's exposure to coal dust to be sufficient for Claimant to develop coal workers' pneumoconiosis if Claimant were a susceptible host. (DX 1 (EX 21, 10:12-16)) Dr. Castle further stated that, with regard to Claimant's last coal mining job as a mine foreman, Claimant's job required some heavy exertion, but most of the time would require only light to moderate exertion. (DX 1 (EX 21, 10:17-11:21)) With regard to Claimant's smoking history, Dr. Castle testified that he found Claimant to have a twenty-nine pack year smoking history, which he said was a significant amount of cigarette smoke exposure, which was sufficient to cause an obstructive lung disease in a susceptible host.[44] (DX 1 (EX 21, 15:6-13))

With regard to his physical examination of Claimant, Dr. Castle testified that he noted no abnormalities. Dr. Castle testified that Claimant did not use his accessory muscles for respiration, which would have indicated that Claimant had a significant degree of pulmonary abnormality; Claimant did not have an increased anteroposterior ("AP") diameter of the chest, which Dr. Castle explained could be significant in certain types of obstructive disease; Claimant had no rales, also known as crepitations or crackles, which are associated with certain kinds of interstitial lung disease such as coal workers' pneumoconiosis; or wheezes or rhonchi, which are often associated with obstructive phenomena or obstructive airway problems. (DX 1 (EX 21, 12:3-13:21)) Dr. Castle testified that the foregoing findings indicated that Claimant "was not having a significant [degree] of obstruction at that point by physical examination." (DX 1 (EX 21, 14:1-3)) Dr. Castle also testified in his deposition that the level of an individual's obstruction can fluctuate. (DX 1 (EX 21, 14:4-6))

[44] Dr. Castle also noted that a twenty pack year smoking history, as found by another physician, would be a sufficient history for Claimant to develop an obstructive lung disease. (DX 1, EX 21, 16:2-6))

With regard to pulmonary function studies in general, Dr. Castle explained how these studies show that an individual has an obstructive impairment:

> When one has an obstructive process, it slows the airflow because of narrowing in the airways. By slowing the airflow, one is not able to get out the same volume of air in a given period of time. So that what we see actually is a reduction in the volume of air that is exhaled in one second as compared to the total amount that's exhaled. So that when we look at the study, we'll see a reduction in the FEV1 when compared to the FVC[, i.e. the FEV1 percent].

(DX 1 (EX 21, 19:11-21))

Thereafter, Dr. Castle stated that the normal range for the FEV1 percent is between 75 and 85 percent and that Claimant's FEV1 percent of 65 indicated that Claimant had a mild degree of obstruction. (DX 1 (EX 21, 20:9-11)) Moreover, with regard to Claimant's pulmonary function study, Dr. Castle testified that it revealed a marked improvement in Claimant's pulmonary function post-bronchodilator. (DX 1 (EX 21, 20:16-21)) Dr. Castle stated that, while some reversibility in impairment post-bronchodilator may be seen in patients with complicated pneumoconiosis, which Claimant clearly did not have, impairments caused by simple coal workers' pneumoconiosis did not respond to bronchodilators. (DX 1 (EX 21, 23:2-11)) Dr. Castle further testified that Claimant could not possibly be suffering from a restrictive process, because his total lung capacity was normal. (DX 1 (EX 21, 25:12-17)) Dr. Castle testified that from "the physiologic point of view" the foregoing finding ruled out the possibility that Claimant had pneumoconiosis. (DX 1 (EX 21, 25:23-26:1)) Dr. Castle explained that pneumoconiosis "has a restrictive component or is a restrictive process, and there was no restrictive process in this case." (DX 1 (EX 21, 25:18-22)) With regard to the variability observed in the results of his study and the studies of Drs. Modi and Myers, Dr. Castle attributed the variation to Claimant's effort given in each study and the fact that Dr. Modi did not use a bronchodilator. (DX 1 (EX 21, 31:7-10))

With regard to the arterial blood-gas studies that he examined, Dr. Castle testified that they revealed that Claimant did not suffer any permanent reduction. (DX 1 (EX 32:8-22)) Dr. Castle testified that PO2 levels are dynamic and could change under some circumstances, although in the case of coal workers' pneumoconiosis, one would not expect to see improvement in the PO2 level. (DX 1 (EX 32:23-23:12)) Lastly, with regard to his opinion that Claimant's mild respiratory impairment (asthmatic bronchitis) was secondary to his cigarette smoking, Dr. Castle stated that he could differentiate between cigarette smoking exposure and coal dust exposure as the cause of Claimant's impairment because the "two diseases are two distinct entities." (DX 1 (EX 21, 37:12-15)) Dr. Castle stated that "[c]oal worker's [sic] pneumoconiosis is medically distinct and legally distinct, I think, from the diseases caused by cigarette smoking." (DX 1 (EX 21, 37:16-22)) Dr. Castle therefore opined that Claimant did not have any dust disease of the lung or sequelae thereof which was significantly related to or substantially aggravated by, in whole or in part, coal dust exposure. (DX 1 (EX 21, 38:3-14))

Dr. Kirk Hippensteel (DX 1 (EX 5, 6, 20))

Dr. Hippensteel, who is Board-certified in internal medicine with a subspecialty in pulmonary disease (DX 1 (EX 5)),[45] in a report dated August 10, 1992, reviewed several medical documents admitted as evidence in Claimant's first claim, including chest x-ray reports, pulmonary function study and arterial blood-gas study results, medical reports summarizing physical examinations performed by other physicians, and other medical data. (DX 1 (EX 5))

Based on his review of the foregoing information, Dr. Hippensteel found that (1) all but one interpretation of Claimant's x-rays were negative, (2) Claimant's pulmonary function studies showed that Claimant had a mild obstruction that "could be corrected to normal with bronchodilator therapy and no evidence of restriction[,]" (3) Claimant's arterial blood-gas studies "showed variable oxygenation associated with a markedly elevated carboxyhemoglobin level on one test suggestive of continued heavy smoking[,]" and (4) Claimant's examinations "proved comments about symptoms but found his lungs clear." Based on these findings, Dr. Hippensteel opined that the "evidence in this case is strongly against coal worker's [sic] pneumoconiosis in this man[,]" and that Claimant "has no permanent pulmonary impairment from any cause" and therefore "should have the respiratory capacity to return to his regular job in the mines."

In a supplemental report dated August 30, 1993, after reviewing additional chest x-ray interpretations, pulmonary function study and arterial blood-gas study results, reports of physical examination, and medical reports written by other physicians, Dr. Hippensteel stated that his opinions as summarized in his original report remained substantially unchanged. (DX 1 (EX 20)) Dr. Hippensteel still opined that Claimant's "mild obstructive impairment with reversibility [was] consistent with his cigarette smoking history and not indicative of coal workers' pneumoconiosis or coal mine related lung disease" and that Claimant "should have the respiratory capacity to return to his regular job in the mines."

In a deposition taken on August 20, 1992, Dr. Hippensteel testified regarding his medical qualifications, his interpretation of a November 27, 1991 chest x-ray, and the findings and opinions contained in his report and supplemental report. (DX 1 (EX 6)) With regard to his interpretation of the November 27, 1991 x-ray, Dr. Hippensteel stated that the irregular markings that he observed were confined to Claimant's lower lung zones and that the "pattern was not specifically suggestive of the coal worker's [sic] type of pneumoconiosis." (DX 1 (EX 6, 12:6-17)) Dr. Hippensteel further testified that "irregular markings in the bases can occur in asbestosis as a separate kind of pneumoconiosis and so such markings get listed on the pneumoconiosis classification sheet" and that "it is also known that such markings are increased in smokers and that such markings can't be separated out from those that would be caused by such things as asbestosis" i.e. would be the same in smokers, "and that this pattern in this particular individual was most consistent with cigarette smoking." (DX 1 (EX 6, 12:17-13:3))

[45] Dr. Hippensteel served as the Assistant Head of the Pulmonary Disease Division of the national Navel Medical Center from 1978 through 1979. Dr. Hippensteel also has published an article dealing with the use of acetylcysteine in life threatening acute bronchial obstruction and an article on the topic of atypical mycobacterium mimicking scar cancer. He has written abstracts and given presentations regarding transnasal fiberoptic bronchoscopy, controversies in present day tuberculosis therapy, new drugs to treat asthma, and bronchodilators.

In his deposition, Dr. Hippensteel also discussed the relevance of carboxyhemoglobin reports in analyzing Claimant's pulmonary condition. Dr. Hippensteel explained that a carboxyhemoglobin test "is a measure of the percentage of carbon monoxide attached to hemoglobin in the bloodstream." (DX 1 (EX 6, 15:20-21)) He explained that "it is a test of recent exposure to carbon monoxide which is a significant component of cigarette smoke or cigar smoke or pipe smoke" and that the "levels of a [nonsmoker], because there are some things in the area that relate to pollution, is usually considered to be up to 2 percent." (DX 1 (EX 6, 15:25-16:6)) Dr. Hippensteel then stated that a "pack-a-day cigarette smoker is usually in the range of 4 to 8 percent carboxyhemoglobin, and a two-pack-a-day smoker is commonly in the range of 8 to 12 percent." (DX 1 (EX 6, 16:11-14)) With regard to how an elevated carboxyhemoglobin level affects arterial blood-gas test results, Dr. Hippensteel testified that a level of eleven percent, such as Claimant had, isn't high enough to affect the results in any significant way. (DX 1 (EX 6, 32:1-13)) Conversely, Dr. Hippensteel stated that, with regard to diffusion studies, this "level of carboxyhemoglobin is enough to decrease artificially the diffusion in such a person" because the "the diffusion study that we test is a carbon monoxide associated test by itself so that if you already have a large amount of carbon monoxide in your bloodstream, then the diffusion test will be falsely lowered because of that fact." (DX 1 (EX 6, 32:14-21))

Thereafter in his deposition, Dr. Hippensteel stated that cigarette smoking and coal mine employment were the two main risk factors he identified for Claimant's pulmonary condition. (DX 1 (EX 6, 16:19-22)) Yet, Dr. Hippensteel later testified that he would not expect coal mine dust exposure to cause the type of lung impairment that Claimant had, especially after Claimant had stopped working in the mines. (DX 1 (EX 6, 25:3-5)) While Dr. Hippensteel testified that there was "some data to suggest [that] industrial bronchitis and heavy dust exposure at the time [one was] in mining [could] produce some obstructive change while [one was] being exposed to such dust" Dr. Hippensteel further testified that "after removing [oneself] from that exposure" obstruction was no longer expected to be a problem, "and so therefore [couldn't] be a component[.]" (DX 1 (EX 6, 25:8-14)) Dr. Hippensteel therefore stated "so the circumstances here are strongly in favor that [Claimant's impairment] is from his cigarette smoking and not related to his coal mining." (DX 1 (EX 6, 25:14-16))

In his deposition, Dr. Hippensteel also discussed Claimant's pulmonary function studies. First Dr. Hippensteel explained how physicians assign individuals different levels of obstructive impairment based on the results of these studies. Dr. Hippensteel explained that any value above eighty percent of what was predicted was considered to be within the normal range. (DX 1 (EX 6, 19:16-20:6)) He testified that FEV_1 values of between sixty-five and eighty percent of predicted indicated a mild degree of obstructive disease, values between fifty and sixty-five percent of predicted indicated a moderate degree of disease, and values below fifty percent of predicted indicated that an individual had a severe degree of obstruction. (DX 1 (EX 6, 20:9-18))

With regard to the reversible component of Claimant's obstruction, as revealed by the studies, Dr. Hippensteel stated that it demonstrated that Claimant's obstruction was airways disease and "therefore tied in with something that [Claimant was] being exposed to at the time." (DX 1 (EX 6, 25:19-21)) Dr. Hippensteel testified that the cause of Claimant's disease was cigarettes and that the fact that it was reversible and therefore not a permanent impairment

demonstrated that it was "something separate from pneumoconiosis as a specific diagnosis." (DX 1 (EX 6, 25:22-26:3)) Dr. Hippensteel further stated that the foregoing was also not consistent with industrial bronchitis. (DX 1 (EX 6, 26:4-9)) With regard to the variation in Claimant's pulmonary function study results, Dr. Hippensteel testified that "in a circumstance of airways disease associated with obstruction from cigarette smoking, we see variability occurring from one month to the next, one year to the next in regards to such airways irritation, and that irritation shows up as a variable change in [one's] function[,]" which Dr. Hippensteel further stated "is the usual in this kind of impairment." (DX 1 (EX 6, 24:14-21)) Lastly, Dr. Hippensteel stated that Claimant's lung volume studies showed that Claimant did not have restrictive lung disease and further stated that Claimant's total lung capacity was normal. (DX 1 (EX 6, 27:10-29:13))

At his deposition, Dr. Hippensteel testified regarding the purpose of arterial blood-gas studies and the significance of differences in an individual's values obtained before and after exercise. (DX 1 (EX 6, 31:29:18-31:14)) Dr. Hippensteel explained that "[d]iffusion abnormality associated with interstitial diseases like [that which] occurs with coal worker's [sic] pneumoconiosis causes a decrease in oxygenation with exercise" (DX 1 (EX 6, 30:3-6)) He explained that the purpose of the test is to help determine "whether exercise impairment is also caused by gas exchange in addition to alterations in ventilation or ventilatory function." (DX 1 (EX 6, 30:6-9)) Dr. Hippensteel further explained that there "are circumstances where hypoxemia occurs at rest that improves with exercise and therefore is not an exercise impairing kind of problem." (DX 1 (EX 6, 30:10-12)) He testified that this "kind of change that improves with exercise is associated with what we call ventilation-perfusion mismatching and that this "kind of problem is frequently associated with obstructive airways diseases" (DX 1 (EX 6, 30:15-18)) He stated that with ventilation-perfusion mismatching, "the air you breathe in doesn't go in equal amounts to the places that your blood flow from your heart goes to in your lungs, and so therefore, it doesn't match up completely to get across into the bloodstream in an efficient way." (DX 1 (EX 6, 30:19-23)) Dr. Hippensteel further explained that with this condition, exercise actually increases one's blood flow through one's lungs, which in turn improves one's overall gas exchange, which is what occurred in Claimant's case. (DX 1 (EX 6, 30:24-31:3)) Dr. Hippensteel testified that the results of Claimant's arterial blood-gas studies were consistent with the findings from his pulmonary function studies and further stated that the "reason that [Claimant] had the findings on the ventilatory studies as we previously mentioned is that cigarette smoking with airways disease does do this kind of thing to your gas exchange." (DX 1 (EX 6, 31:4-9)) Dr. Hippensteel affirmed that the foregoing findings were consistent with what one would expect to find in someone who had an obstructive impairment related to a particular history of cigarette smoking. (DX 1 (EX 6, 31:20-23))

Overall, Dr. Hippensteel testified that he did not believe Claimant had either clinical or legal pneumoconiosis and further testified that he did not believe that Claimant's mild obstructive reversible lung disease would keep him from resuming his regular employment as an underground coal miner. (DX 1 (EX 6, 32:22-34:1)) Dr Hippensteel testified that he believed Claimant's respiratory status would be the same even if Claimant had never been a miner. (DX 1 (EX 6, 34:2-5))

Dr. Gregory Fino (DX 1 (EX 8, 19))

Dr. Fino, who is Board-certified in internal medicine with a subspecialty in pulmonary disease, on April 8, 1993, reviewed several medical documents submitted as evidence in this case (chest x-rays, pulmonary function studies, arterial blood-gas studies, reports of physical examinations, medical reports, and other medical data). (DX 1 (EX 8)) After reviewing the foregoing medical evidence, Dr. Fino found that (1) the chest x-ray evidence favored a finding of no pneumoconiosis; (2) the pulmonary function studies showed that Claimant did not suffer from a permanent restrictive ventilatory defect, exhibited improvement/reversibility in his impairment following bronchodilators, and elevated lung volumes; and (3) the arterial blood-gas studies revealed a lack of an impairment in oxygen transfer. Based on these findings, Dr. Fino concluded that there was "insufficient objective medical evidence to justify a diagnosis of simple coal workers' pneumoconiosis" and that Claimant did "not suffer from an occupationally acquired pulmonary condition." Dr. Fino further opined that, even if Claimant did have simple coal workers' pneumoconiosis, Claimant did not suffer from a respiratory impairment and retained "the necessary physiologic capacity from a respiratory standpoint to perform this last mining job or a job requiring similar effort."

In a supplemental report dated August 31, 1993, Dr. Fino reviewed additional medical evidence that had been submitted as part of Claimant's first claim.[46] (DX 1 (EX 19)) After reviewing this additional evidence, Dr. Fino stated that he still opined that Claimant neither had an occupationally acquired pulmonary condition, nor did he "show any impairment from a respiratory standpoint that would prevent him from returning to his last mining job or a job requiring similar effort." Dr. Fino noted that some of the medical evidence he reviewed (part of Dr. Castle's August 19, 1993 report) indicated that Claimant's respiratory obstructive abnormality was totally reversible and that "the marked reversibility that was seen on earlier pulmonary function testing [was] quite indicative of a non-occupationally acquired pulmonary condition." Dr. Fino concluded by stating that it was still his "opinion that [Claimant was] neither partially nor totally disabled from returning to his last mining job or a job requiring similar effort."

Medical Opinions Submitted as Part of Claimant's March 30, 1998 Claim

Dr. Rasmussen (DX 2 (DX 11, 12 and CX 7))

Dr. Rasmussen, who is Board-certified in internal medicine (DX 2 (DX 12)), examined Claimant on April 22, 1998.[47] In a report written that same day (DX 2 (DX 11, 12)), Dr.

[46] All of the medical evidence reviewed by Dr. Fino is in evidence, except for an arterial blood-gas study performed by Dr. Myers on April 20, 1993. In light of the substantial other evidence (including six other arterial blood-gas studies) relied on by Dr. Fino in rendering his opinions in his report, this Administrative Law Judge does not find that Dr. Fino's report should be accorded less weight based on the fact that Dr. Fino relied, to a nominal degree, on Dr. Myers' study which is not in the record. *See Harris v. Old Ben Coal Co.*, 23 B.L.R. 1-98 (2006).

[47] Dr. Rasmussen may have examined Claimant on April 22 or 27, 1998. The Form CM 988 notes the exam and tests were on April 27, 1998. The test reports and summary state the tests and examination were performed on April 22, 1998.

Rasmussen summarized Claimant's employment history (final position of twenty year mining career was as a mine foreman and involved considerable heavy manual labor), family history, social history (smoked one pack of cigarettes per day since age eighteen), and medical history (history of pneumonia and subjective complaints of sputum, wheezing, dyspnea, cough, orthopnea, ankle edema, and paroxysmal nocturnal dyspnea).[48] Dr. Rasmussen also noted Claimant's then current medications which included Dyliz/Dytuss, Ketoprofen, and a Proventil inhaler.

As part of his examination, Dr. Rasmussen physically examined Claimant (chest expansion reduced, breath sounds moderately reduced, and prolonged expiratory phase with forced respirations), read the Claimant's chest x-ray (1/1, p/p), and performed a pulmonary function study (minimal obstructive ventilatory impairment and moderately reduced single breath carbon monoxide diffusing capacity ("SBDLCO") and DL/VA), arterial blood-gas study (moderate to marked impairment in oxygen transfer), and electrocardiogram (sinus bradycardia, but otherwise within normal limits).

Dr. Rasmussen opined that the Claimant had coal workers' pneumoconiosis ("CWP") based on his twenty years of coal mine employment and x-ray changes and chronic obstructive pulmonary disease ("COPD") based on his chronic productive cough and airflow obstruction. He opined that Claimant's CWP was caused by coal mine dust exposure and that Claimant's COPD was caused by coal mine dust exposure and cigarette smoking. He further opined that Claimant had moderate to severe loss of lung function and was totally disabled from performing his last regular coal mine job. Dr. Rasmussen stated that coal mine dust exposure "must be considered at least a major contributing factor in view of the fact that the impairment in oxygen transfer significantly exceed[ed] the ventilatory impairment in this case."

In a separate report (DX 2 (CX 7)), dated November 20, 2000, Dr. Rasmussen again examined Claimant. As part of this examination, Dr. Rasmussen again obtained Claimant's employment, social/smoking, family, and medical histories, which were substantially the same as that obtained as part of his April 22, 1998 examination.[49] He physically examined Claimant (chest expansion normal, breath sounds moderately reduced, and prolonged expiratory phase and wheezing with forced respirations), had Claimant's chest x-ray read (1/1, p/p), and performed a pulmonary function study (moderate, slightly reversible obstructive insufficiency, maximum breathing capacity markedly reduced and SBDLCO moderately reduced), arterial blood-gas study (minimal resting hypoxia and marked impairment in oxygen transfer during mild exercise), and electrocardiogram (sinus bradycardia, but otherwise within normal limits).

Dr. Rasmussen again opined that the Claimant had marked impairment in his respiratory function. He further opined that this degree of impairment rendered Claimant totally disabled for any significant gainful employment. Also, like in his earlier report, Dr. Rasmussen stated that,

[48] Dr. Rasmussen noted that Claimant was smoking one pack of cigarettes per day at the time of the exam and that Claimant began smoking in 1967 at the age of eighteen. This Claimant actually turned eighteen in 1963.

[49] The only substantial difference in the histories obtained by Dr. Rasmussen was with regard to Claimant's smoking history. In his second examination, Dr. Rasmussen correctly noted the year Claimant turned eighteen (1963) and began smoking and further noted that Claimant stated that he had quit smoking two days before the exam.

based on Claimant's significant history of exposure to coal mine dust and x-ray, it was medically reasonable to conclude that Claimant had coal workers' pneumoconiosis and that his disabling respiratory impairment was caused by Claimant's cigarette smoking as well as Claimant's coal mine dust exposure, which was a major contributing factor. Dr. Rasmussen noted that Claimant had a history consistent with asthma, but further noted that "the asthma [was] not a major contributing factor to his impairment."

Dr. Robinette (DX 2 (CX 4, 6))

Dr. Robinette, who is Board-certified in internal medicine with a subspecialty in pulmonary disease (DX 2 (CX 6)),[50] examined Claimant on August 2, 1999. His findings are summarized in an undated report (DX 2 (CX 4)). In his report, by way of background, Dr. Robinette mentioned that he examined Claimant in 1985 and found that, at that time, Claimant exhibited x-ray evidence of simple pneumoconiosis but normal pulmonary function and arterial blood-gas studies.[51] As part of his current examination, Dr. Robinette noted Claimant's employment history (seventeen years in the mining industry, performing a variety of duties that involved substantial dust exposure, including working as a foreman), social history (then smoking one half pack of cigarettes per day and had an approximate thirty pack year smoking history), and medical history (medications of Theo-24 600 mg. q.d., Proventil 2 puffs q.i.d., Lufyllin Syrup as needed, Orudis p.r.n. for arthyritis and Tessalon Perles for cough and subjective complaints of shortness of breath on exertion, cough and congestions and chronic sputum production, orthopnea, paroxysmal nocturnal dyspnea, and some chest pain).

As part of his examination, Dr. Robinette also physically examined Claimant (chest had increased AP diameter, on auscultation breath sounds were diminished, bilateral expiratory wheezes present, marked prolongation of the expiratory phase, and rhonchi present in both lung bases), read Claimant's x-ray (1/0, q/q, with underlying emphysema), and performed a pulmonary function study (moderate obstructive lung disease with evidence of air trapping and a reduction in the diffusion capacity), arterial blood-gas study (mild resting hypoxemia with elevation of the serum carboxyhemoglobin level compatible with underlying chronic cigarette consumption), and electrocardiogram (within normal limits). Based on the foregoing, Dr. Robinette provided the following opinions:

1. Simple coal workers' pneumoconiosis with a profusion abnormality of 1/0, predominant Q opacities with underlying emphysema.
2. Moderate obstructive lung disease with evidence of reduction in the diffusion capacity, hypoxemia and an elevation of the carboxyhemoglobin level.
3. Degenerative arthritis with chronic back pain.

[50] Dr. Robinette has given a presentation entitled "Pneumonia in the Face of Occupational Lung Disease" and has severed as a pulmonary consultant/attending physician and Clinical Director of Respiratory Care Services at Johnston Memorial Hospital from 1983 through 1996 and as a pulmonary consultant at Russell County Medical from 1986 through 1996.

[51] Dr. Robinette's 1985 report is not in evidence. After reviewing Dr. Robinette's undated report summarizing the findings of his August 2, 1999 examination, this Administrative Law Judge finds that Dr. Robinette did not rely to any relevant degree on his former report in rendering the opinions contained in his current report and that Dr. Robinette's report should not be accorded less weight. *See Harris v. Old Ben Coal Co.*, 23 B.L.R. 1-98 (2006).

4. Dupuytren's contracture of palmar fascia of the left hand.

Dr. Robinette noted that Claimant "ha[d] evidence of simple pneumoconiosis and ha[d] evidence of progressive airflow obstruction with rapid deterioration of his FEV1 and FVC." He opined that Claimant's "pulmonary condition [was] at least partially attributable to his prior coal mining exposure, but additionally [was] related to his chronic cigarette consumption." Dr. Robinette concluded by stating that Claimant's "prognosis [was] guarded in view of the rapid deterioration of his lung function over the past 10 years."

Dr. Castle (DX 2 (EX 5, 6, 10, 21, 22))

Dr. Castle, who is Board-certified in internal medicine with a subspecialty in pulmonary disease (DX 2 (EX 6, 22)), examined Claimant on November 5, 1998. His findings are summarized in a report dated May 6, 1999. (DX 2 (EX 5)) In his report, Dr. Castle summarized Claimant's family history, employment history (throughout the various positions Claimant held during his twenty year mining career, including his last position as a mine foreman, Claimant was required to perform heavy labor), and smoking history (thirty five pack-year smoking history: one pack per day since approximately the age of eighteen until around four months before the exam when Claimant reduced his smoking to half a pack per day). Dr. Castle also noted Claimant's medical history (history of pneumonia and subjective complaints of difficulty with lungs since 1985, shortness of breath, some chest pain, cough productive of some phlegm on a daily basis since 1980, and wheezing) and Claimant's current medications (Dytuss and Lufyllin GG, Theo-24, Orudis, Vanceril, and other inhalers).

As part of his examination, Dr. Castle physically examined Claimant (nothing remarkable) and reviewed a chest x-ray (0/1), pulmonary function study (moderate airway obstruction without significant improvement after bronchodilator), arterial blood-gas study (carboxyhemoglobin level markedly elevated at 10.3% which is consistent with smoking in excess of two packages of cigarettes daily), and electrocardiogram report. Based on the foregoing, Dr. Castle arrived at the following conclusions:

1. No evidence of coal workers' pneumoconiosis by physical examination, radiographic evaluation, physiologic testing, and arterial blood gases.
2. Chronic bronchitis, tobacco smoke induced.
3. Moderate airway obstruction secondary to No. 2.
4. Markedly elevated carboxyhemoglobin level consistent with ongoing tobacco abuse habit.
5. History of back and hip injury.

In his report, Dr. Castle then noted that he reviewed his August 19, 1993 report and the evidence summarized therein, as well as x-ray interpretations of an April 22, 1998 x-ray by Drs. Patel, Cole, and Navani, and the medical report written by Dr. Rasmussen on April 22, 1998 and the objective medical evidence produced in connection with that report. Thereafter, based on his review of all the foregoing data, Dr. Castle opined that, although Claimant had worked for a sufficient amount of time in coal mines to develop coal workers' pneumoconiosis, Claimant did not suffer from the disease. Dr. Castle also opined that Claimant's pulmonary disease and

symptoms were caused by Claimant's continued habit of abusing tobacco after he quit working in the mines.

Dr. Castle noted that "[a]t no time did [Claimant] demonstrate consistent findings indicating the presence of an interstitial pulmonary process such as would be expected with clinically significant coal workers' pneumoconiosis." Dr. Castle pointed out that there were no consistent findings of rales, crackles, or crepitations. He also stated that he did not believe Claimant's chest x-rays provided evidence of pneumoconiosis and that, while the pulmonary function studies showed a mild to moderate degree of airway obstruction, there had been essentially no change in these studies since the studies performed in 1993. Dr. Castle stated that Claimant exhibited a significant degree of reversibility in his airway obstruction and that this finding was indicative of tobacco smoke induced airway obstruction and chronic bronchitis. Dr. Castle also noted that there was no evidence that Claimant suffered from a restrictive process and that "[w]hen coal workers' pneumoconiosis causes clinically significant impairment it does so by causing a mixed, irreversible obstructive and restrictive ventilatory defect" which Claimant did not exhibit in this case. Dr. Castle further noted that "[t]he minimal degree of reduction in [Claimant's] diffusing capacity [was] significantly influenced by his markedly elevated carboxyhemoglobin level." Dr. Castle also noted that, while Claimant's arterial blood-gas studies showed that Claimant had a mild degree of hypoxemia, Claimant's condition was not attributable to either coal workers' pneumoconiosis or his previous coal mining employment exposure. Dr. Castle again emphasized that Claimant had not been inside of a coal mine since 1986 and that in 1993 there was no evidence that Claimant has hypoxemia associated with his previous employment. Dr. Castle stated that "ongoing tobacco abuse causes ventilation/perfusion mismatch which results in variable degrees of hypoxemia." Dr. Castle concluded that Claimant neither suffered from, nor was totally disabled by, "a chronic dust disease of the lungs, or the sequelae thereof, that has been caused by, contributed to, or substantially aggravated by coal mine dust exposure."

In a supplemental report dated December 13, 1999, Dr. Castle reviewed the medical report by Dr. Emery Robinette who examined Claimant on August 2, 1999. (DX 2 (EX 10).) After reviewing this report Dr. Castle stated that nothing in that report altered any of the opinions he expressed in his May 6, 1999 report. Specifically, Dr. Castle stated:

> [Claimant] has had no additional coal mining exposure or coal dust exposure since 1986 when he left the mining industry due to a back injury. In 1985 he was noted by Dr. Robinette to have entirely normal respiratory function. Again, he has had no further dust exposure. What is significant is that he has had continued very high-level tobacco smoke exposure. His carboxyhemoglobin level at the time of my examination in 1998 was essentially 10.0%. The level was essentially unchanged at Dr. Robinette's examination at 9.4%. Both of these are consistent with someone who is smoking in excess of 1 ½ packs of cigarettes daily. This on-going, high level exposure to the products of tobacco smoke does cause progressive respiratory dysfunction. One does not develop progressive respiratory dysfunction in the absence of further coal dust exposure if there is no evidence of dysfunction at the time of leaving the coal mines. In this specific case [Claimant] did not have evidence of either pulmonary dysfunction or coal

> workers' pneumoconiosis after leaving the mining industry. Currently he has developed evidence of at least moderate airway obstruction which is purely and simply tobacco smoke induced.

Dr. Castle further stated that there was no other substantiating evidence in this case to justify a diagnosis of coal workers' pneumoconiosis and reiterated his findings from his May 6, 1999 report regarding the medical evidence submitted in this case. Dr. Castle noted that Claimant had (1) "the physical findings associated with tobacco smoke induced chronic obstructive pulmonary disease[;]" (2) "[h]is chest x-ray show[ed] evidence of hyperinflation associated with tobacco smoking[;]" and (3) "[h]is physiologic studies [were] clearly indicative of tobacco smoke induced airway obstruction manifested by a reduction in the FEV1/FVC ratio with some degree of improvement after bronchodilator therapy, normal total lung capacity, elevated residual volume, and mild reduction in the diffusing capacity."

On December 26, 2000, Dr. Castle wrote a second supplemental report. (DX 2 (EX 21)) In this report, Dr. Castle reviewed the medical report and test results generated by Dr. Rasmussen in conjunction with his November 20, 2000 examination of Claimant. In this report, Dr. Castle stated that he still found that Claimant did not suffer from coal workers' pneumoconiosis based on the fact that the majority of the x-rays were read as negative for the disease and Dr. Rasmussen's pulmonary function study showed evidence of moderate airway obstruction with a significant degree of reversibility after bronchodilators, significant airway obstruction without restriction, reduced diffusing capacity, and a mild degree of hypoxemia at rest and after exercise. Dr. Castle opined that all of the foregoing findings were related to Claimant's long and extensive tobacco smoking history and that the decline noted by Dr. Rasmussen in Claimant's "ventilatory function can only be attributed to his ongoing tobacco smoking habit." He further opined that Claimant was not "permanently and totally disabled as a result of coal workers' pneumoconiosis or any other process arising from his coal mining employment duties." Rather, Dr. Castle opined that Claimant was "permanently and totally disabled as a result of tobacco smoke induced chronic obstructive pulmonary disease." Dr. Castle concluded by stating that "[a]ny change that has occurred in [Claimant's] ventilatory function and arterial blood gases since the time of my last report clearly has to be related to his ongoing tobacco smoking habit."

Dr. Fino (DX 2 (EX 7, 11, 20, 22, 23))

In a medical report written on June 1, 1999, by Dr. Fino, who is Board-certified in internal medicine with a subspecialty in pulmonary disease (DX 2 (EX 22)), Dr. Fino reviewed all of the medical evidence summarized in his previous reports, which were submitted in connection with Claimant's first claim, as well as the medical reports written by Dr. Castle on May 6, 1999 and Dr. Rasmussen on April 22, 1998. (DX 2 (EX 7)). After reviewing this evidence Dr. Fino stated that his prior opinions, as stated in his previous reports, dated April 8, 1993 and August 31, 1993, were unchanged. Dr. Fino reiterated his opinion that Claimant had a mild obstructive abnormality caused by his long standing and continued smoking history. Dr. Fino further opined that the abnormality was not disabling and that Claimant was capable of returning to his last mining job or a job of similar effort.

In another supplemental report dated December 15, 1999 (DX 2 (EX 11)), Dr. Fino reviewed a medical report written by Dr. Robinette who examined Claimant on August 2, 1999. Based on his review of Dr. Robinette's report, in addition to the other information he had already reviewed, Dr. Fino opined that Claimant did "not suffer from an occupationally acquired pulmonary condition as a result of coal mine dust exposure." Dr. Fino stated that he based his opinion on the following two findings. First, the majority of x-ray readings were negative for pneumoconiosis. Second, the pulmonary function studies revealed that Claimant had an obstructive ventilatory abnormality that "occurred in the absence of any interstitial abnormality," which has reduced Claimant's small airway flow more so than his large airway flow, which was not consistent with coal dust related conditions, but was consistent with conditions such as cigarette smoking, pulmonary emphysema, non-occupational chronic bronchitis, and asthma. Moreover, while minimal obstructive lung disease, called industrial bronchitis, had been described in working coal miners, this condition was characterized by cough and mucous production, as well as minimal decreases in the FEV_1 in some miners, and resolved within six months of leaving the mines. Furthermore, while obstructive lung disease could arise from coal workers' pneumoconiosis, it occurred when significant fibrosis was present.

Dr. Fino further noted that, while it had been shown that Claimant had mild hypoxia, the condition was not disabling. Dr. Fino opined that, while Claimant's pulmonary system was abnormal from a functional standpoint, "he retain[ed] the physiologic capacity, from a respiratory standpoint, to perform all the requirements of his last job." Dr. Fino noted that, while there were two risk factors for Claimant's impairment (coal mine dust exposure and smoking), the clinical information in this instance was consistent with a smoking related impairment. Dr. Fino stated that "[e]ven if industrial bronchitis due to coal mine employment contributed to the obstruction, the loss in the FEV1 would be in the 200 cc range." He noted that the foregoing "medical estimate of loss in FEV1 in working miners was summarized in [a] 1995 NIOSH document [and] that although a statistical drop in the FEV1 was noted in working miners, that drop was not clinically significant." In closing, Dr. Fino summarized his conclusions:

1. There is insufficient objective medical evidence to justify a diagnosis of simple coal workers' pneumoconiosis.
2. It is my opinion that this man does not suffer from an occupationally acquired pulmonary condition.
3. There is a mild respiratory impairment present due to smoking.
4. From a respiratory standpoint, this man is neither partially nor totally disabled from returning to his last mining job or a job requiring similar effort.
5. Even if I assume that this man has medical or legal pneumoconiosis, it has not contributed to his disability. He would be as disabled had he never stepped foot in the mines.

In a final supplemental report dated December 26, 2000, Dr. Fino again reviewed all the medical evidence previously reviewed as well as a portion of the medical report and test results by Dr. Rasmussen that were part of his November 20, 2000 examination of Claimant.[52] (DX 2 (EX 20)) Thereafter, in his report, Dr. Fino summarized the medical literature concerning the

[52] Dr. Fino only received and reviewed the first page of Dr. Rasmussen's narrative report. He did not receive or review the physical examination portion of Dr. Rasmussen's medical report.

pulmonary health of coal miners. Based on all the foregoing data, Dr. Fino concluded that Claimant was now suffering from a moderate respiratory impairment secondary to smoking and, from a respiratory standpoint, was now disabled.

In a deposition taken on January 11, 2001, Dr. Fino discussed his medical qualifications and opinions regarding Claimant's pulmonary health. (DX 2 (EX 23)) In his deposition, Dr. Fino testified that, based on his review of the medical evidence, he determined that Claimant had worked a total of seventeen years in the mining industry. (DX 2 (EX 2, 9:24-25)) He also stated that, based on Dr. Rasmussen's 2000 report, he believed that Claimant at that time had been working for nine months in a rock quarry. (DX 2, (EX 23, 10:8-10))

Thereafter, Dr. Fino stated that the two risk factors for Claimant's respiratory impairment were Claimant's coal mine dust exposure and Claimant's history of cigarette smoking. (DX 2 (EX 23, 10:15-22)) Dr. Fino testified that Claimant had a minimum pack year history of thirty seven pack years and that Claimant had smoked approximately one pack per day since 1963. (DX 2 (EX 23, 10:19-22))

In his deposition, Dr. Fino also explained that an elevated carboxyhemoglobin meant that one had inhaled a product of combustion, the most common of which was cigarette smoke. (DX 2 (EX 23, 11:4-7)) He also stated that the high carboxyhemoglobin levels noted by Drs. Castle and Robinette during their recent examinations of Claimant "represent[ed] at least a package of cigarettes per day." (DX 2 (EX 23, 11:12-12:6)) Dr. Fino stated that in individuals with Claimant's smoking history, one might see obstruction that "may or may not show improvement" with bronchodilators, reduction in PO2 levels with exercise, and reduction in the diffusing capacity." (DX 2 (EX 23, 12:7-13))

With regard to whether Claimant's most recent pulmonary function studies revealed any change in Claimant's condition from what was shown in Claimant's pulmonary function studies performed in the early 1990's, Dr. Fino stated that the new studies demonstrated that Claimant had developed a fixed obstructive abnormality, which had worsened between April of 1998 and November of 2000. (DX 2 (EX 23, 13:10-23)) He testified that, based on Dr. Rasmussen's November 2000 evaluation, he believed Claimant's condition was disabling. (DX 2 (EX 23, 13:24-14:8))

When asked whether a history of coal dust exposure that ceased in 1986 could begin to cause impairment in 1998, Dr. Fino testified that it could. (DX 2 (EX 23, 14:9-12)) Dr. Fino further stated that it was important to look at what type of impairment an individual was suffering from and noted that Claimant had developed a purely obstructive abnormality. (DX 2 (EX 23, 14:12-16)) Dr. Fino testified that, while in coal mine dust-related disease there was an obstruction that had been observed in working miners called industrial bronchitis or COPD in miners related to coal mine dust inhalation, what the NIOSH studies had shown was that, while there could be a reduction in the FEV_1 in some miners, that reduction occurred early on in the miner's working career. (DX 2 (EX 23, 14:17-15:2)) Dr. Fino testified that once the obstruction developed, the obstruction would either "go away while the miner continued to work in the mine or it [would] remain." (DX 2 (EX 23, 15:2-4)) Dr. Fino further stated that, "based on that fact, one would expect at or about the time that a miner leaves the mines or shortly thereafter, if he or

she sustained a COPD type impairment due to coal mine dust inhalation, that it would be detectible on lung function studies." (DX 2 (EX 23, 15:5-10))

Dr. Fino pointed out that Claimant did not have any obstructive abnormality for "up to six to seven years after he left the mines." (DX 2 (EX 23, 15:14-24)) Although Dr. Fino acknowledged that Claimant did have a history of asthma, he testified that he didn't feel that any of the lung function studies between 1991 and 1993 revealed evidence of asthma. (DX 2 (EX 23, 15:25-16:6)) Dr. Fino acknowledged that pneumoconiosis could be progressive in some cases and that "pneumoconiosis included a whole lot of conditions." (DX 2 (EX 23, 19:11-16)) Dr. Fino stated that Claimant's development of an obstructive abnormality long after he left the mines was not consistent with the type of COPD or airway obstruction that can occur as a result of coal mine dust inhalation. (DX 2 (EX 23, 16:7-12, 19:17-21)) Dr. Fino testified that it was, however, consistent with a smoking related abnormality. (DX 2 (EX 23, 16:15-22, 19:21-24))

With regard to Claimant's specific impairment, Dr. Fino testified that Claimant's impairment had a reversible component, although the majority of the obstruction was irreversible. (DX 2 (EX 23, 16:23-25)) Dr. Fino stated that this was consistent with a smoking related abnormality. (DX 2 (EX 23, 17:1-3)) With regard to Claimant's reduced diffusing capacity, Dr. Fino stated that he believed it indicated that Claimant had emphysema, which he said was consistent with Claimant's smoking history. (DX 2 (EX 23, 19:25-20:6)) Dr. Fino thereafter testified that he believed Claimant's arterial blood-gas studies validated the finding that Claimant had mild hypoxemia, which Dr. Fino opined to be disabling after exercise. (DX 2 (EX 23, 20:7-23)) With regard to Claimant's history of asthma, Dr. Fino stated that it was only "significant to the extent that there are studies in the medical literature to suggest that cigarette smoking can have more of an effect on someone's lungs if they start out with another condition such as asthma or some other respiratory disease process." (DX 2 (EX23, 20:24-21:7)) Moreover, Dr. Fino stated that with Claimant's smoking history, he expected that any deterioration in his lung function due to smoking would continue, even if he stopped smoking. (DX 2 (EX 23, 21:8-19)) Dr. Fino later noted that, while the damage caused by coal mine dust and cigarette smoking could be similar, the two exposures affected the lungs differently, which explained why Claimant's smoking history would continue to affect Claimant after the exposure had stopped, while coal mine dust exposure would not. (DX 2 (EX 23, 29:5-30:15))

In his deposition, Dr. Fino also discussed his thoughts regarding the medical literature he summarized in his December 26, 2000 report. (DX 2 (EX 23, 22:22-31:17)) With regard to how he used the literature in his analysis, Dr. Fino testified that he considered both host susceptibility and mine effect in Claimant's case, but that with regard to mine effect, he had no information. (DX 2 (EX 25:2-14)) Dr. Fino testified that "host susceptibility" referred to the fact that "some individuals will react more to inhaling substances than other" and that "mine effect" referred to "a combination of total coal mine dust inhaled in the lungs." (DX 2 (EX 23, 23:12-20))

Dr. Fino also testified that he believed it was possible for coal mine dust inhalation to cause obstruction in COPD, and that, in some miners, coal dust inhalation could be responsible, in whole or in part, for a miner's pulmonary disability. (DX 2 (EX 23, 27:21-28:3)) Dr. Fino further testified that in the case of miners, like Claimant, who have more than one significant exposure that can be the cause of that miner's impairment, Dr. Fino stated that "in those

situations … there are factors that can be utilized to determine [the cause of the impairment]: total coal dust exposure versus total smoking exposure; onset of obstruction in relationship to when or if the patient stopped working in the mines and when or if the patient stopped smoking." (DX 2 (EX 23, 28:4-17)) Dr. Fino also noted that bronchodilator response, knowing if a patient had a child respiratory disease or a history of respiratory disease could make smoking more significant that coal-dust related disease, and patterns of change over time could be helpful. (DX 2 (EX 23, 28:17-22)) He further stated that "although one does not entirely, by any stretch of the imagination, rely on the chest x-ray as ruling in or ruling out pneumoconiosis, abnormalities on the chest x-ray due to pneumoconiosis are a direct consequence of the total coal content in the lung, which is clearly the culprit in coal dust-related lung disease. (DX 2 (EX 23, 28:23-29:4))

F. Other Medical Evidence

Treatment Notes and Reports of Drs. Lipron, Brasfield, Freeman, and licensed psychologist Pantaze, and decisions of the Social Security Administration and U.S. Magistrate for the District of Western Virginia (DX 1 (DX 37))

The documents submitted as part of Director's Exhibit 37 in Claimant's first federal claim for benefits (Director's Exhibit 1 in the current claim) involve Claimant's 1986 back injury. These documents do not address Claimant's pulmonary condition.

Treatment Notes from The Clinic (DX 1 (DX 32))

Included in the record are Claimant's hospitalization and treatment records from The Clinic, written by Dr. Larry Mitchell, dated September 8, 1986 through February 3, 1989. These records document the miner's treatment for various ailments, including, in relevant part, treatment for an "[u]pper respiratory infection superimposed on COPD" (3/8/88) and COPD (9/8/86). The records also document that as of September 8, 1986, Claimant was smoking a pack of cigarettes a day (9/8/86).

V. Issue 1: Timely filing of Claimant's claim

Pursuant to 20 C.F.R. §725.308, a "claim for benefits filed under this part by, or on behalf of, a miner shall be filed within three years after a medical determination of total disability due to pneumoconiosis which has been communicated to the miner or a person responsible for the care of the miner, or within three years after the date of enactment of the Black Lung Benefits Reform Act of 1977, whichever is later." 20 C.F.R. §725.308(a). On the other hand, although the foregoing time limits are mandatory and may not be waived or tolled, except upon a showing of extraordinary circumstances, there "shall be a rebuttable presumption that every claim for benefits is timely filed." 20 C.F.R. §725.308(c). Moreover, the Fourth Circuit Court of Appeals has stated that "a medical determination later deemed to be a misdiagnosis of pneumoconiosis by virtue of a superseding denial of benefits cannot trigger the statute of limitations for subsequent claims. *Consolidation Coal Co. v. Director, OWCP*, 453 F.3d 609, 618 (4th Cir. 2006).

In this case, Employer has asserted that Claimant's claim, filed on August 30, 2004, was

untimely. In a motion to dismiss filed with the district director, Employer argued that Dr. Rasmussen's April 22, 1998 medical determination and Dr. Robinette's August 2, 1999 medical determination triggered the three year statute of limitations. (DX 22 and 28.) Yet, in this case, the Administrative Law Judge presiding over Claimant's last claim for benefits, which was finally decided on June 15, 2001, found that Claimant did not have either clinical or legal pneumoconiosis. Thus, because this case arises in the Fourth Circuit, Drs. Rasmussen's and Robinette's medical determinations are deemed misdiagnoses and do not trigger the statute of limitations for Claimant's current claim. Accordingly, because Employer has failed to establish a triggering communicated medical determination between June 15, 2001 and August 30, 2004, therefore this Administrative Law Judge finds that Claimant's current claim was timely filed.

VI. Issue 2: Length of Coal Mine Employment[53]

In both of Claimant's prior claims, the Administrative Law Judges adjudicating those claims credited Claimant with sixteen (16) years of coal mine employment. (DX 1 and 2.) Accordingly, for the purpose of determining whether there has been a change in a condition of entitlement, this Administrative Law Judge will accept as correct the finding by Judge Tureck in Claimant's last claim that Claimant worked sixteen years as a miner. *Consolidation Coal Co. v. Director, OWCP*, 453 F.3d 609, 615-16 (4th Cir. 2006); *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358, 1361-62 (4th Cir. 1996), cert. denied, 519 U.S. 1090 (1997).

For subsequent claims, the regulations specifically state under what circumstances issues adjudicated in prior claims can and cannot be re-litigated. The regulations state that "[i]f the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, *except those based on a party's failure to contest an issue (see § 725.463)*, shall be binding on any party in the adjudication of the subsequent claim." 20 C.F.R. § 725.309(d)(4)(emphasis added). "However, any stipulation made by any party in connection with the prior claim shall be binding on that party in the adjudication of the subsequent claim." 20 C.F.R. § 725.309(d)(4). Thus, if Claimant successfully proves that there has in fact been a change in a condition of entitlement, this Administrative Law Judge will also accept as correct Judge Tureck's finding that Claimant has sixteen years of coal mine employment for the purpose of adjudicating Claimant's current claim *de novo*.

In this case, although the length of Claimant's coal mine employment was originally listed as an issue contested by Employer on the Form CM-1025 in Claimant's second claim, at the hearing before Judge Tureck, when asked if Employer objected to Judge DiNardi's finding of sixteen years of coal mine employment in connection with Claimant's first claim, Employer stated that it did not intend to present any evidence on the issue of coal mine employment.[54]

[53] This Administrative Law Judge notes that Employer has not challenged the fact that Claimant, when he worked for coal companies, worked as a miner as defined in 20 C.F.R. § 725.202(a) of the regulations. Moreover, this Administrative Law Judge further notes that Claimant's uncontroverted testimony establishes that, as a miner, Claimant worked since the age of eighteen in underground coal mines and that Claimant's duties included mining coal, rock dusting, and acting as mine foreman.

[54] 20 C.F.R. § 725.462 states that a "party may, on the record, withdraw his or her controversion of any or all issues set for hearing."

(DX 1 at TR 5:1-7.) Judge Tureck accepted Employer's statement as a withdrawal of its controversion of the issue. (DX 1 at TR 5:7-9.) Accordingly, this Administrative Law Judge finds that Employer did not contest the issue of the length of Claimant's coal mine employment in connection with Claimant's last federal claim for benefits and therefore may not do so now in connection with Claimant's current claim. Thus, this Administrative Law Judge finds that Claimant has sixteen years of coal mine employment for the purpose of adjudicating Claimant's current claim.[55]

VII. Issues 3-7: The Standard for Entitlement

In this case, the Claimant filed his claim after April 1, 1980, and bears the burden of establishing each of the following elements by a preponderance of the evidence: (1) Claimant has pneumoconiosis; (2) the pneumoconiosis arose out of coal mine employment; (3) Claimant is totally disabled; and (4) the pneumoconiosis contributes to Claimant's total disability. 20 C.F.R. §725.202(d)(2). Failure to establish any one of these elements precludes entitlement to benefits.

A. Change in a Condition of Entitlement: Existence of Pneumoconiosis

In the Claimant's last federal black lung claim, the Administrative Law Judge ("ALJ") found that Claimant had proven by a preponderance of the evidence that he was totally disabled; but, the Administrative Law Judge found that Claimant had not proven that he had pneumoconiosis as defined by the regulations. (DX 2.) Accordingly, the Claimant could not have had pneumoconiosis arising from his coal mine employment or pneumoconiosis contributing to his total disability. Thus, in the instant case, in order to have his subsequent claim adjudicated, Claimant must prove by a preponderance of the new evidence of record that he has pneumoconiosis , legal or clinical.

In the regulations, pneumoconiosis is defined as a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 20 C.F.R. § 718.201(a). The disease is recognized as being "a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure." 20 C.F.R. § 718.201(c). Under the amended regulations, the definition of pneumoconiosis includes both clinical and legal pneumoconiosis:

> (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition

[55] This Administrative Law Judge notes that even if Employer were not estopped by 20 C.F.R. §725.309(d)(4) from re-litigating the issue, the decision in this case would not be affected. In this case, this Administrative Law Judge finds that the evidence of record establishes that Claimant worked for *at least* fourteen years as a coal miner. *See, e.g., supra* note 6; DX 1 (DX 2-8); DX 2 (DX 5 and 2). Accordingly, the presumption set forth in 20 C.F.R. § 718.203 would still be applicable in this case. This Administrative Law Judge further notes that in its post-hearing brief, Employer conceded that "Claimant worked approximately twenty years in the coal mining industry which ended in 1986." (Employer's Br. 20.)

> includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

20 C.F.R. § 718.201(a)(1)-(2). For the purpose of defining pneumoconiosis, "a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. § 718.201(b).

The regulations state that the existence of pneumoconiosis may be established by any of the following methods: (1) chest x-rays; (2) autopsy or biopsy; (3) by operation of presumption; or (4) by a physician exercising sound medical judgment based on objective medical evidence.[56] 20 C.F.R. § 718.202(a). In the Fourth Circuit, a claimant must establish by a preponderance of *all* relevant evidence of record that he has pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000).

Chest x-rays

When weighing chest x-ray evidence, the provisions at 20 C.F.R. § 718.202(a)(1) require that "where two or more x-ray reports are in conflict, in evaluating such x-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such x-rays." In this vein, the Board has held that it is proper to accord greater weight to the interpretation of a B-reader or board-certified radiologist over that of a physician without these specialized qualifications. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Allen v. Riley Hall Coal Co.*, 6 B.L.R. 1-376 (1983). Moreover, an interpretation by a dually-qualified B-reader and board-certified radiologist may be accorded greater weight than that of a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128 (1984).

In this case, six interpretations of three chest x-rays have been submitted as part of Claimant's current claim that relate to the issue of change in conditions. After reviewing the radiological qualifications of the physicians who read Claimant's x-rays, this Administrative Law Judge notes that three dually qualified physicians interpreted Claimant's x-rays as positive for type p/s opacities, with progression 1/1, present in all lung zones; a B-reader interpreted one of Claimant's x-rays as revealing type s/t opacities, with progression 0/1, present only in the lower right and left lung zones; and two dually qualified physicians interpreted Claimant's x-rays as negative. None of the doctors diagnosed complicated pneumoconiosis

[56] There is no autopsy or biopsy evidence in this record and the presumptions contained at 20 C.F.R. §§ 718.304 - 718.306 are inapplicable in this case.

Accordingly, in this case, based on the foregoing interpretations, this Administrative Law Judge finds that the preponderance of the evidence does not support a finding that Claimant's x-rays are completely negative. Notably, four of the six physicians read Claimant's x-rays as positive for the presence of opacities. Moreover, of those four interpretations, three readings of two different x-rays were done by dually qualified physicians, who all made the exact same findings regarding the type (p/s), level of progression (1/1), and location (all lung zones) of opacities revealed by Claimant's x-rays. In this case, this Administrative Law Judge finds the foregoing identical interpretations by three dually qualified physicians to be very compelling evidence that Claimant's x-rays are positive and therefore finds that the preponderance of the chest x-ray evidence in this case reveals that Claimant now suffers from clinical pneumoconiosis.

Medical Opinions

The final method by which this Claimant can establish that he suffers from pneumoconiosis is by well-reasoned, well-documented medical opinions rendered by physicians exercising sound medical judgment based on objective medical evidence, such as blood-gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. *See* 20 C.F.R. 718.202(a)(4). A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's history. *See Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984).

A "reasoned" opinion is one in which the administrative law judge finds the underlying documentation adequate to support the physician's conclusions. *Fields, supra*. Indeed, whether a medical opinion is sufficiently documented and reasoned is for the administrative law judge as the finder-of-fact to decide. *See Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc). Legal pneumoconiosis may be established by well-reasoned medical opinions which support a finding that the miner's pulmonary or respiratory condition is significantly related to or substantially aggravated by coal dust exposure. *See Wilburn v. Director, OWCP*, 11 B.L.R. 1-135 (1988).

In weighing the opinions, more weight may be accorded to a medical report containing the most recent physical examination of the miner because it is likely to contain a more accurate evaluation of the miner's current condition. *Gillespie v. Badger Coal Co.*, 7 B.L.R. 1-839 (1985); *Bates v. Director, OWCP*, 7 B.L.R. 1-113 (1984); *Kendrick v. Kentland-Elkhorn Coal Co.*, 5 B.L.R. 1-730 (1983). An opinion which is better supported by the objective medical evidence of record may be accorded greater probative value, *Minnich v. Pagnotti Enterprises, Inc.*, 9 B.L.R. 1-89, 1-90 n.1 (1986); *Wetzel v. Director, OWCP*, 8 B.L.R. 1-139 (1985). An opinion that fails to provide rationale and does not explain what evidence in the record supports the opinion may be discredited, *see Harkey v. Alabama By-Products Corp.*, 7 B.L.R. 1-26 (1984).

In this case, three physicians' opinions regarding whether Claimant has pneumoconiosis were submitted as part of Claimant's most recent claim. Of these physicians, one physician (Dr.

Rasmussen) opined that Claimant has both clinical and legal pneumoconiosis, and two physicians (Drs. Castle and Fino) opined that Claimant has neither form of the disease. Accordingly, the varying opinions of these three physicians must be individually evaluated. In doing so, this Administrative Law Judge has taken into consideration the relationship between the miner and the physicians, the qualifications of the physicians, whether the opinions were well-documented and well-reasoned, whether the reports were internally consistent, and whether the opinions relied on, and otherwise were consistent with, the objective medical evidence admitted into the record.[57]

All three opinions are well-documented. In this case, Drs. Fino, Castle, and Rasmussen each based their opinions on either thorough examination of Claimant or thorough review of the medical evidence of record. In formulating their opinions, all three physicians fully considered the relevant aspects of Claimant's employment, smoking, and medical histories, respiratory symptoms, and the results of credible, objective medical tests.

With regard to the relationship between each physician and the miner, this Administrative Law Judge notes that none of the physicians are a treating physician of the miner. Accordingly, no additional weight has been accorded to any of the three opinions based on the miner's relationship with any of the physicians. Moreover, in view of the fact that pneumoconiosis is recognized to be both a latent and progressive disease, this Administrative Law Judge finds that the opinions of Dr. Fino and Dr. Castle should not be accorded more weight based on the fact that they reviewed the medical evidence submitted in connection with Claimant's two prior claims. This Administrative Law Judge notes that the foregoing evidence predates the evidence submitted as part of Claimant's current claim by three or more years. Additionally, this Administrative Law Judge does not find that the opinions of Drs. Fino or Castle should be accorded more weight solely on the ground that these physicians reviewed the other medical evidence submitted in connection with Claimant's current claim. Overall, what is relevant in this case is not whether the physicians reviewed the other medical evidence of record, but rather, whether the physicians' opinions are consistent with, and supported by, this other evidence.

With regard to the physicians' qualifications, this Administrative Law Judge notes that all three physicians are Board-certified in internal medicine and that Drs. Fino and Castle are both Board-certified in the subspecialty of pulmonary disease. Yet, in this case, notwithstanding the fact that Dr. Rasmussen is not Board-certified in the subspecialty of pulmonary disease, this Administrative Law Judge finds Dr. Rasmussen's credentials to be the most relevant. As previously noted, of the three physicians, Dr. Rasmussen has the most extensive and relevant experience involving miners, pneumoconiosis, and smoking. Accordingly, this Administrative Law Judge finds that Dr. Rasmussen's opinion is entitled to substantial weight.

Next, with regard to the physicians' opinions of whether Claimant has clinical pneumoconiosis, this Administrative Law Judge finds that Dr. Rasmussen's opinion is well reasoned and consistent with, and supported by, the other new objective medical evidence of

[57] Here, both Dr. Fino and Dr. Rasmussen cite to general medical literature in support of their analysis of whether Claimant has legal pneumoconiosis. However, none of the literature cited by either physician is in the record. Accordingly, no additional weight has been accorded to either physician's opinion based on that physicians' assertion that his opinion is supported by unidentified general medical literature.

record, while the opinions of Dr. Castle and Dr. Fino are not. In this case, as previously summarized, Dr. Rasmussen opined that, based on a positive chest x-ray interpretation by Dr. Patel, a dually qualified physician, and Claimant's coal mine employment history, Claimant has simple coal workers' pneumoconiosis ("CWP") secondary to his coal mine dust exposure. In this case, this Administrative Law Judge finds the foregoing evidence to be sufficient to provide an adequate basis upon which Dr. Rasmussen could base his opinion. Moreover, this Administrative Law Judge notes that Dr. Rasmussen's opinion is consistent with this Administrative Law Judge's finding regarding the x-ray evidence of record and Claimant's treatment records, which document that Claimant's treating physicians Dr. Bell, Dr. Forehand, and Dr. Freeman believe that Claimant has CWP.

Conversely, this Administrative Law Judge finds Dr. Castle's and Dr. Fino's opinions that Claimant does not have clinical pneumoconiosis are not consistent with the underlying documentation of the case. To the extent that the physicians based their opinions on their findings that the new x-ray evidence of record does not establish that Claimant has the disease, their opinions are based on findings contrary to this Administrative Law Judge's finding regarding that evidence. Moreover, to the extent that the physicians considered and relied on the overall numerical superiority of negative x-ray interpretations rendered in connection with all of the Claimant's prior and current claims, this Administrative Law Judge notes that the evidence is consistent with the latent and progressive disease process of pneumoconiosis. The x-ray evidence of record, considered by Dr. Fino and Dr. Castle, spans a period that is over two decades (September 1985 through July 2006). The x-ray evidence submitted in connection with this period reveals a gradual shift in the opinions of the dually qualified physicians over time: (1) in Claimant's first claim, there were *no* positive x-ray interpretations by dually qualified physicians; (2) in the Claimant's second claim, there were *five negative* interpretations and *three positive* interpretations by dually qualified physicians (2 – 1/0, 1 – 1/1); and (3) in the current claim, there are *two negative* interpretations and *three positive* interpretations (all 1/1) by dually qualified physicians. Accordingly, this Administrative Law Judge finds that the physicians' reliance on the numerical superiority of the negative interpretations of Claimant's chest x-ray is inappropriate under the circumstances of this case.

With regard to Dr. Castle, to the extent that he relied on his findings that Claimant's physical examinations, pulmonary function studies, and arterial blood-gas studies revealed no impairment indicative of CWP in formulating his opinion, this Administrative Law Judge notes that none of the foregoing evidence directly negates the x-ray evidence, which reveals that Claimant has abnormalities consistent with CWP present in his lungs.[58] Rather, the foregoing

[58] Dr. Castle stated in his September 14, 2005 report that he based his opinion on (1) his findings that Claimant had no physical findings indicating that he has the disease; (2) his own x-ray interpretation and his finding that the vast majority of Claimant's other x-rays were interpreted as negative for the disease; (3) his finding that Claimant's recent physiologic studies (pulmonary function studies) demonstrated that Claimant has a moderate airway obstruction associated with hyperinflation, gas trapping, and reduction in the diffusing capacity, rather than a mixed, irreversible obstructive and restrictive ventilatory defect, which he asserts is normally associated with the disease; (4) and his finding that Claimant's arterial blood-gas studies reveal that Claimant has a mild degree of hypoxemia at rest that worsens with exercise, which Dr. Castle opined was caused by Claimant's reduced diffusion capacity (which he stated was not normally associated with CWP until there was a high degree of profusion of either type p or r opacities) and Claimant's ventilation perfusion mismatching problem, which Dr. Castle opined was due to what he asserts is tobacco smoked induced emphysema, although he acknowledges that the problem can also occur in association with CWP.

findings are evidence of the extent to which the abnormalities (opacities) in Claimant's lungs may be contributing to his respiratory impairment. Indeed, Dr. Castle himself noted the presence of opacities in Claimant's lungs, although he noted a progression of 0/1 and opined that the opacities were caused by Claimant's history of cigarette smoking.

Finally, Dr. Fino's and Dr. Castle's opinions are in conflict with the opinions, diagnosis and course of treatment expressed by Claimant's treating physicians, as demonstrated in the Claimant's treatment records. Accordingly, this Administrative Law Judge finds that Dr. Rasmussen's opinion, that Claimant has clinical pneumoconiosis, deserves controlling weight on the issue of the presence of clinical pneumoconiosis in this case.

With regard to the physicians' opinions of whether Claimant has legal pneumoconiosis, all three physicians have opined that Claimant suffers from chronic obstructive pulmonary disease ("COPD") associated with emphysema. Additionally, Dr. Fino opined that Claimant's COPD also consists of a chronic bronchitic component. All three physicians have opined that Claimant's respiratory impairment, which consists of a moderate, partially reversible, obstructive condition and hypoxia/hypoxemia, is secondary to Claimant's COPD. After reviewing the opinions of the physicians and the evidence of record, this Administrative Law Judge finds that the medical opinions that Claimant currently suffers from COPD and that this disease is a cause of Claimant's respiratory impairment are well-reasoned and supported by the objective medical evidence submitted as part of the current claim.

With regard to the physicians' opinions of whether coal mine dust was a contributing factor of Claimant's COPD, this Administrative Law Judge finds that Dr. Rasmussen's opinion is well-reasoned and consistent with the objective medical evidence of record. As previously summarized, Dr. Rasmussen opined that Claimant's COPD is secondary to both his coal mine dust exposure and cigarette smoking. In his report, Dr. Rasmussen noted that Claimant has a significant history of coal dust exposure [59] and stated that both coal mine dust and cigarette smoke "cause lung tissue destruction indistinguishable by x-ray exam, physical examination or physiologic measurements and are independent of x-ray abnormalities." Dr. Rasmussen further stated that "[c]oal mine dust exposure [can] also cause impairment in oxygen transfer, which is out of proportion or absent ventilatory impairment as in [Claimant's] case" and opined that "coal mine dust exposure [was] a major contributing factor in [Claimant's] disabling lung disease." Here the underlying documentation upon which Dr. Rasmussen relied supports his conclusion that coal mine dust was a contributing cause of Claimant's COPD. The Claimant's cigarette smoking and coal mine dust exposure histories are significant and the abnormalities Dr. Rasmussen noted in Claimant's x-ray, physical exam, pulmonary function study, and arterial blood-gas study are consistent with the definition of legal pneumoconiosis set forth in the regulations. Accordingly, this Administrative Law Judge finds that the legal pneumoconiosis causation opinion of Dr. Rasmussen is entitled to substantial weight.

The opinions of Dr. Castle and Dr. Fino that cigarette smoke is a contributing cause of Claimant's COPD are consistent but their opinions regarding coal mine dust not playing a role in Claimant's disease are based on beliefs that are inconsistent with the regulations and the medical

[59] Based on Claimant's testimony at the hearing, this Administrative Law Judge finds that Dr. Rasmussen's finding is more accurate.

and occupational evidence as a whole. With regard to Dr. Castle's opinion, this Administrative Law Judge notes that Dr. Castle never specifically explained in his report his reasoning for excluding coal mine dust, *independent of CWP*, as a contributing cause of Claimant's pulmonary impairment, i.e. why coal mine dust is not a contributing cause in Claimant's COPD. Dr. Castle's deposition testimony leads to the conclusion that he believes that a miner cannot have legal pneumoconiosis independent of CWP. In his deposition, Dr. Castle testified that coal mine dust does not typically cause the same type of emphysema that is associated with tobacco smoke. Dr. Castle reported that coal mine dust can cause a type of (focal) emphysema that is "part of the pathologic description of coal workers' pneumoconiosis" and further stated that in order for a miner to have *coal mine dust-induced emphysema*, he would have to have CWP. In light of the fact that legal pneumoconiosis is a broader definition than clinical pneumoconiosis and therefore encompasses disease processes that are independent of clinical pneumoconiosis, including chronic obstructive impairments, this Administrative Law Judge finds Dr. Castle's opinion to be based on a rationale that is inconsistent with the regulations.[60] Specifically, this Administrative Law Judge finds that Dr. Castle has *categorically excluded* pulmonary emphysema, that is independent of CWP, from "occupationally-related pathologies." Moreover, in light of the fact that Dr. Castle acknowledged that (1) the Claimant has a sufficient coal mine dust exposure history to develop pneumoconiosis, (2) Claimant's pulmonary impairment is partially irreversible, (3) coal mine dust can cause a purely obstructive pulmonary impairment, and (4) pneumoconiosis can be latent and progressive, this Administrative Law Judge finds that Dr. Castle's exclusion of coal mine dust induced respiratory impairment is not adequately supported by the medical evidence in this case and that Dr. Castle's ultimate opinion on legal pneumoconiosis is entitled to little weight.

Similarly, this Administrative Law Judge also finds the opinion of Dr. Fino, who made the same acknowledgements in his deposition as Dr. Castle, to be of little weight.[61] This Administrative Law Judge notes that Dr. Fino cited several pieces of medical literature in support of his opinion but none of that literature is in the record for review or evaluation. Accordingly, this Administrative Law Judge cannot determine if in fact Dr. Fino's interpretation of that literature is accurate or if his reliance on that literature in this case is justified. Thus, under these circumstances, this Administrative Law Judge cannot say that the underlying

[60] *See Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969*, 65 Fed. Reg. 79,919, 79,937-45 (Dec. 20, 2000) ((1) stating in the comments for 20 C.F.R. § 718.201 that the revised definition of pneumoconiosis eliminates the need for litigating the issue of whether coal mine dust exposure can cause chronic obstructive pulmonary disease on a claim-by-claim basis, and renders invalid as inconsistent with the regulations medical opinions which categorically exclude obstructive lung disorders from occupationally-related pathologies; (2) stating that [w]hether a particular miner's disability is due to his coal mine employment or smoking habit must be resolved on a claim-by-claim basis under the criteria set for at § 718.204[;]" and (3) citing with approval medical literature documenting that coal mine dust exposure can cause chronic airflow limitation and emphysema that may be independent of CWP).

[61] Dr. Fino based his opinion in part on his finding that the degree of Claimant's impairment has varied over time. Dr. Fino has asserted that such variation is evidence that Claimant is not suffering from a progressive coal mine dust related disease because such variation is not consistent with diseases caused by coal mine dust, that are permanent in nature. Yet, in light of the fact that Claimant's impairment is, at least in part, permanent and irreversible, Dr. Fino's finding is not in fact evidence that Claimant's impairment is not caused, at least in part, by coal mine dust. This Administrative Law Judge further discredits the weight of Dr. Fino's finding since he based his finding of "variability" in part on the pulmonary function studies submitted in connection with Claimant's first claim of which almost all of those studies were found by several physicians to be invalid.

documentation upon which Dr. Fino relied is adequate to support his conclusions. This Administrative Law Judge also finds that, to the extent Dr. Fino based his opinion of no coal mine dust contribution to the Claimant's COPD on his conclusion that there was no evidence that Claimant suffered from any impairment for at least five or six years after he quit working as a miner, Dr. Fino's opinion is inconsistent with the regulations. Again, it is noted that the regulations recognize that pneumoconiosis is a latent and progressive disease that may become detectible only after the cessation of coal mine dust exposure. To the extent that Dr. Fino based his opinion on his finding that Claimant did not inhale or retain enough coal mine dust in his lungs to cause Claimant to develop a clinically significant increase in his obstructive impairment, this Administrative Law Judge finds that Dr. Fino's opinion is based on a finding contrary to the finding that Claimant has a significant history of coal dust exposure.

Accordingly, this Administrative Law Judge finds that the opinions of Dr. Castle and Dr. Fino regarding whether coal mine dust substantially contributes to Claimant's COPD are entitled to little weight and that Dr. Rasmussen's opinion is the most persuasive and entitled to substantial weight. This Administrative Law Judge further finds that Claimant has established by a preponderance of the new medical evidence of record that coal mine dust is a substantially contributing cause of Claimant's COPD, that he has pneumoconiosis, and that this constitutes a change in condition from the prior June 15, 2001 judicial denial of his claim filed March 30, 1998 (DX 2) as required by 20 C.F.R. § 725.309(d).

B. Full Review of the Record

In this case, as summarized above, the record contains numerous x-ray interpretations, pulmonary function studies, arterial blood-gas studies, medical opinions, treatment records, and the transcripts of Claimant's testimony from three hearings. Overall, the evidence of record spans a period of more than two decades. Accordingly, in deciding this case, while this Administrative Law Judge has considered all of the relevant evidence of record, this Administrative Law Judge has accorded controlling weight to the evidence submitted as part of Claimant's current claim. Under the circumstances of this case, this Administrative Law Judge finds that the foregoing evidence most accurately reflects Claimant's *current* condition. Specifically, this Administrative Law Judge notes that the evidence submitted in connection with Claimant's first claim predates the evidence submitted in connection with Claimant's current claim by ten or more years, while the evidence submitted as part of Claimant's second claim predates the evidence submitted in connection with Claimant's current claim by at least three years. Accordingly, while the evidence submitted in connection with Claimant's first two claims may accurately reflect Claimant's condition in the past, it does not necessarily provide much probative evidence of Claimant's post-2001 respiratory and occupational condition in the present.

1. Element 1: Existence of Pneumoconiosis

After fully reviewing the record, this Administrative Law Judge finds that Claimant has established by a preponderance of the evidence that he now suffers from pneumoconiosis. After review of the evidence submitted in connection with Claimant's prior two claims, this Administrative Law Judge finds that there is no other evidence in the record that contradicts this

Judge's finding that Claimant *now* has pneumoconiosis. Again, this Administrative Law Judge notes that pneumoconiosis is recognized as a latent and progressive disease. Accordingly, the fact that the preponderance of the evidence from Claimant's first and second claims may be insufficient to establish that Claimant had pneumoconiosis at the time that either of those claims was decided is not evidence that Claimant does not now suffer from the disease. This Administrative Law Judge finds that the most recent medical evidence of record most accurately reflects Claimant's current condition and that the opinions rendered by the physicians given weight in connection with Claimant's most recent claim are based on a full and accurate understanding of the relevant aspects of Claimant's life and medical history. Accordingly, for the reasons just stated, after reviewing the entire record, this Administrative Law Judge continues to find that Claimant has established the existence of pneumoconiosis in the current claim.

2. Element 2: Etiology of Pneumoconiosis

The regulations at 20 C.F.R. § 718.203(a) state that "[i]n order for a claimant to be found eligible for benefits under the Act, it must be determined that the miner's pneumoconiosis arose at least in part out of coal mine employment." The regulations further provide that, if a miner suffers from pneumoconiosis and has engaged in coal mine employment for ten years or more, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b).

In this case, it has been established that Claimant worked as a coal miner for sixteen years. It has also been established that Claimant now suffers from pneumoconiosis. Accordingly, regulations require the rebuttable presumption that the Claimant's pneumoconiosis arose out of his coal mine employment. Thus, unless Employer can rebut this presumption, Claimant is entitled to a finding in his favor regarding this element. After reviewing the evidence of record, this Administrative Law Judge finds that the Employer has failed to rebut the presumption.

First, with regard to the cause of Claimant's clinical pneumoconiosis, this Administrative Law Judge notes that the only rebuttal evidence in this case is provided by Dr. Castle, who opined that the opacities in Claimant's lungs are due to cigarette smoke. Yet, in this case, Dr. Castle testified in his deposition that when interpreting Claimant's chest x-ray, he did not see evidence of coal workers' pneumoconiosis, i.e. rounded opacities in Claimant's upper lung zones. Instead, Dr. Castle noted irregular shaped opacities (type s/t) present in Claimant's lower lung zones. Accordingly, under the circumstances of this case, where this Administrative Law Judge finds that Claimant has simple category I coal workers' pneumoconiosis consisting of type p/s opacities present in all six lung zones, Dr. Castle's opinion is insufficient to rebut the presumption that Claimant's clinical pneumoconiosis arose, at least in part, out of his coal mine employment. Specifically, Dr. Castle's causation opinion does not provide an adequate explanation of the cause of all of the abnormalities (type p/s opacities in Claimant's upper and middle lung zones and type p opacities in Claimant's lower lung zones) that are present in Claimant's lungs.

Next, with regard to the cause of Claimant's legal pneumoconiosis, several physicians who provided opinions in connection with Claimant's first claim, and Dr. Fino and Dr. Castle, who provided opinions in connection with Claimant's second and current claims, opined that claimant's pulmonary impairment is secondary to cigarette smoke. However, with regard to the opinions of Dr. Castle and Dr. Fino, as discussed in the foregoing section, this Administrative Law Judge has found that their opinions, regarding whether coal mine dust is a contributing cause of Claimant's COPD, are entitled to little weight. Accordingly, their opinions are insufficient to rebut the presumption that Claimant's COPD arose, at least in part, out of Claimant's coal mine employment.

With regard to the physicians who provided opinions in connection with Claimant's first claim, this Administrative Law Judge also finds their opinions to be insufficient to rebut the presumption in this case. Overall, the evidence of record demonstrates that Claimant's pulmonary condition has significantly changed since the time his first claim was decided. Specifically, this Administrative Law Judge notes that the majority of physicians at that time believed that Claimant's condition was extremely mild or that Claimant's condition was completely reversible. Presently, Claimant is suffering from a chronic obstructive pulmonary disease. In this case, the physicians' opinions regarding the cause of Claimant's impairment in the early 1990's cannot be applied to Claimant's current impairment causation and therefore finds these opinions to be insufficient to rebut the presumption that Claimant's pneumoconiosis arose, at least in part, out of Claimant's coal mine employment.

Accordingly, this Administrative Law Judge finds that has failed to rebut the presumption that the Claimant has established by a preponderance of the evidence that his pneumoconiosis arose out of his coal mine employment.

3. Element 3: Total Disability

Benefits are provided under the Act for, or on behalf of, miners who are totally disabled due to pneumoconiosis. 20 C.F.R. § 718.204(a). In determining whether a miner is totally disabled due to pneumoconiosis, the regulations state that "any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered" … but if "a nonpulmonary or nonrespiratory condition or disease causes a chronic respiratory or pulmonary impairment, that condition or disease shall be considered in determining whether the miner is or was totally disabled due to pneumoconiosis." 20 C.F.R. § 718.204(a). The regulations also state that a miner shall be considered totally disabled if the irrebuttable presumption prescribed in 20 C.F.R. § 718.304 applies or if the miner has a pulmonary or respiratory impairment which, standing alone, prevents the miner from performing his usual coal mine work and also prevents the miner from engaging in other employment requiring skills and abilities comparable to those used by the miner, "with some regularity over a substantial period of time," while he worked as a miner. 20 C.F.R. § 718.204(b)(1).

Twenty C.F.R. § 718.204(b) provides the following five methods for establishing total disability: (1) 20 C.F.R. § 718.304 irrebuttable presumption; (2) qualifying pulmonary function

studies; (3) qualifying blood-gas studies; (4) evidence of cor pulmonale with right-sided congestive heart failure;[62] and (5) reasoned medical opinions.[63]

Pulmonary Function Studies

Total disability may be established through a preponderance of qualifying pulmonary function studies. The quality standards for pulmonary function studies are set forth in 20 C.F.R. § 718.103 and require, in relevant part, that (1) each study be accompanied by three tracings, *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984), (2) the reported FEV_1 and FVC or MVV values constitute the best efforts of three trials, and, (3) for testing conducted after January 19, 2001, a flow-volume loop be provided. In weighing the studies, the administrative law judge may accord less probative value to those studies where the miner exhibited "poor" cooperation or comprehension. *Runco v. Director, OWCP*, 6 B.L.R. 1-945 (1984).

The current claim contains two conforming pulmonary function studies (dated 11/3/04 and 7/20/05). Under the regulations at 20 C.F.R. § 718.204(b)(2)(i) an individual of Claimant's gender (male), height (67 inches) and age (59 on 11/3/04 and 60 on 7/20/05) may be found totally disabled if the FEV_1 test results of a conforming study are less than or equal to 1.84 (for age 59)/1.83 (for age 60) and the FVC is less than or equal to 2.33 (for age 59)/2.31 (for age 60), or MVV is less than or equal to 73 (for age 59)/72 (for age 60), or the FEV_1 /FVC ratio is less than or equal to 55%. Here the 11/3/04 FEV_1 was 1.99 post-bronchodilator and above the regulation initial screening score. However, both the pre-bronchodilator 1.67 and post-bronchodilator 1.75 test reading of the qualifying 7/20/05 pulmonary function test meet the regulation's initial criteria and both the corresponding MVV of 53 and FEV_1 /FVC ratio of 54.58% pre-bronchodilator and 53.85% post-bronchodilator meet the secondary regulation requirements to establish total disability.

As previously discussed, the record contains several post-2001 nonconforming studies[64] that were submitted with Claimant's treatment records and are of questionable value as to whether Claimant is in fact totally disabled pursuant to 20 C.F.R. § 718.204(b)(2)(i). Specifically, because it is unknown whether the values obtained in the nonconforming studies represent Claimant's best efforts, this Administrative Law Judge cannot reasonably know whether the initial FEV_1 values in those studies are indeed qualifying or non-qualifying: a greater effort on the part of Claimant in any given nonconforming study could have resulted in either an increase or decrease in the actual FEV_1 , FVC, and MVV values obtained in those studies. Accordingly, the only real information that the studies provide, in this instance, regarding the FEV_1 , FVC, MVV and FEV_1/FVC ratios, is that the values are very close to qualifying. This is not contrary probative evidence.

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[62] The 20 C.F.R. § 718.304 irrebuttable presumption is inapplicable in this case and there is no evidence of cor pulmonale with right-sided congestive heart failure. Accordingly, these methods of establishing total disability will not be discussed further.

[63] The Board has held that a judge cannot rely solely upon lay evidence to find total disability in a living miner's claim. *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103 (1994).

[64] 8/18/03, 2/17/05 and 6/20/06 studies lacked notation on effort and cooperation; 3/20/06 and 6/20/06 lacked required tracings

Additionally, this Administrative Law Judge notes that there is no other evidence in the record, which contradicts that Claimant is currently totally disabled pursuant to 20 C.F.R. § 718.204(b)(2)(i). As previously stated, the earlier studies contained in the record do not accurately reflect Claimant's current pulmonary condition and therefore cannot be considered contrary probative evidence with respect to the July 20, 2005 studies. Accordingly, this Administrative Law Judge finds that Claimant has proven by a preponderance of the pulmonary function study evidence of record that he is totally disabled pursuant to 20 C.F.R. § 718.204(b)(2)(i).

Arterial Blood-gas Studies

Total disability may also be established by qualifying blood-gas studies under 20 C.F.R. § 718.204(b)(2)(ii). To be qualifying for arterial blood-gas studies performed at test sites up to 2,999 feet above sea level, the PO2 values corresponding to the PCO2 values must be equal to or less than those found in the Table (1) of Appendix C of 20 C.F.R. Part 718.

In this case, the overwhelming majority of the new arterial blood-gas studies qualify under the regulations. The 9/21/01 higher resting PO2 of 61 is below the table value 63 corresponding to the PCO2 test result of 37. The 8/18/03 PO2 of 63 is below the table value 66 corresponding to the PCO2 test result of 34. The 11/3/04 higher resting PO2 of 73 is above the table value 63 corresponding to the PCO2 test result of 37. The 11/3/04 lower exercise PO2 of 58 is below the table value 65 corresponding to the PCO2 test result of 35. The 2/17/05 PO2 of 61 is equal to the table value 61 corresponding to the PCO2 test result of 39. The 7/20/05 PO2 of 62.3 is below the table value 66 corresponding to the PCO2 test result of 33.9.

Only one of the studies performed after Claimant's second claim was finally denied does not qualify. The 3/20/06 PO2 of 68 is above the table value 64 corresponding to the PCO2 test result of 36. While this study is the most recent study in the record, post-exercise values were not obtained for this study. Moreover, the pre-exercise values for this study are even lower than the pre-exercise values obtained in the November 3, 2004 study. This Administrative Law Judge finds that these pre-exercise studies are not conclusive evidence that Claimant is not now totally disabled pursuant to 20 C.F.R. § 718.204(b)(2)(ii) and that the post-2001 decision arterial blood-gas studies, as a whole, corroborate the degree of disability evidenced by the corresponding pulmonary function studies and that Claimant is totally disabled pursuant to 20 C.F.R. § 718.204(b)(2)(ii).

Medical Opinion Evidence

The final method by which Claimant may establish total disability is through medical opinion evidence, wherein a physician has exercised reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, to conclude that the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine or comparable employment. 20 C.F.R. § 718.204(b)(2)(iv).

As evidence in Claimant's current claim, three physicians' opinions have been submitted into the record: the opinions of Dr. Rasmussen, Dr. Fino, and Dr. Castle. In this case, all three

physicians opined that Claimant is now totally disabled from a respiratory standpoint. This is consistent with the 2001 judicial decision that the Claimant was totally disabled. Additionally, this Administrative Law Judge notes that the opinions of Drs. Rasmussen, Fino, and Castle are consistent with, and supported by, the evidence of record, including, the Claimant's recent testimony regarding his current pulmonary condition; the Claimant's treatment notes; and the medical opinions rendered by Drs. Rasmussen, Robinette, Castle, and Fino in connection with Claimant's second claim and which establish that Claimant has likely been totally disabled as of that time.[65]

Accordingly, this Administrative Law Judge finds that Claimant has established by a preponderance of the medical opinion evidence of record that he is now totally disabled pursuant to 20 C.F.R. § 718.204(b)(2)(iv).

4. Element 4: Establishing Total Disability Due to Pneumoconiosis

In order to establish that he is entitled to benefits under the Act, a miner must establish that his pneumoconiosis is a "substantially contributing cause" of his total disability. 20 C.F.R. § 718.204(c)(1). The regulations define "substantially contributing cause" as a cause that either:

> (i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or
>
> (ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

20 C.F.R. § 718.204(c)(1). The regulations provide that the cause or causes of a miner's total disability shall be established by means of "a physician's documented and reasoned medical report."[66] 20 C.F.R. § 718.204(c)(2). For cases that fall within the jurisdiction of the Fourth Circuit, a physician who finds that a miner's respiratory impairment is caused by more than one factor is not required to precisely determine the extent (percentage) to which each factor contributed to the impairment. *Consolidation Coal Co. v. Director, OWCP*, 453 F.3d 609, 622 (4th Cir. 2006). Rather, it is sufficient that the administrative law judge ("ALJ") "be persuaded, on the basis of all available evidence, that pneumoconiosis is a contributing cause of the miner's disability." *Id.* (internal citation omitted).

Moreover, in deciding cases falling within the jurisdiction of the Fourth Circuit, "an ALJ who has found (or has assumed *arguendo*) that a claimant suffers from pneumoconiosis and has total respiratory disability may not credit a medical opinion that the former did not cause the latter unless the ALJ can and does identify specific and persuasive reasons for concluding that

[65] Dr. Rasmussen, Dr. Castle, and Dr. Fino opined that Claimant was totally disabled. Dr. Robinette stated in his report that Claimant's "prognosis [was] guarded in view of the rapid deterioration of his lung function over the past 10 years."

[66] The following exceptions are permitted under 20 C.F.R. § 718.204(c)(2): cases where the presumption prescribed in 20 C.F.R. § 718.305 is applicable; cases where total disability is established by proving the miner suffered from cor pulmonale with right-sided congestive heart failure as set forth in 20 C.F.R. § 718.204(b)(iii); and in certain circumstances where causation may be proven by lay testimony as set forth in 20 C.F.R. § 718.204(d).

the doctor's judgment on the questions of disability causation does not rest upon [his] disagreement with the ALJ's finding as to either or both of the predicates in the causal chain." *Scott v. Mason Coal Co.*, 289 F.3d 263, 269 (4th Cir. 2002)(referring to the Court's holding in *Toler v. Eastern Associated Coal Co.*, 43 F.3d 109 (4th Cir. 1995)). Yet, even in instances where the ALJ finds that such contrary opinions are entitled to any weight at all, at most, these opinions may be accorded very little weight. *Id.*

In this case, while several physicians have provided medical opinions in connection with all three of Claimant's claims, only Dr. Rasmussen opined that Claimant has both legal and clinical pneumoconiosis and that Claimant is totally disabled due to pneumoconiosis.

With regard to the other medical opinions submitted in connection with Claimant's first claim, they are of no probative value. Specifically, this Administrative Law Judge finds that, while some the physicians (Dr. Forehand, Dr. Sargent, and Dr. Myers) opined that Claimant may have had pneumoconiosis at the time, none of the physicians opined that Claimant was then totally disabled. Since pneumoconiosis can be latent and progressive, the opinions rendered in connection with Claimant's first claim are over a decade old, and this Administrative Law Judge has found that the Claimant's condition has significantly changed since the time his first claim was decided, this Administrative Law Judge finds that these opinions are entitled on no weight.

With regard to the physicians who rendered opinions in connection with Claimant's second and third claims, this Administrative Law Judge finds that these opinions have some probative value and are therefore entitled to limited weight. First, with regard to Dr. Robinette, he did not specifically find that Claimant was totally disabled at the time he rendered his opinion; but, Dr. Robinette did clearly believe that Claimant was very disabled. While the degree of Claimant's impairment has changed since the time Claimant's second claim was decided, this Administrative Law Judge finds that the nature of Claimant's diagnosis has remained a partially irreversible obstructive impairment since the time of his second claim. Accordingly, Dr. Robinette's disability causation opinion, under these circumstances has probative value.

With regard to Dr. Castle and Dr. Fino, this Administrative Law Judge finds that their opinions, notwithstanding their statements to the contrary, rest on their respective findings that Claimant does not have clinical pneumoconiosis.[67] For reasons noted earlier, this Administrative Law Judge finds that the opinions of Dr. Castle and Dr. Fino, regarding whether Claimant's total disability is substantially caused by Claimant's clinical pneumoconiosis, are entitled to no weight. With regard to Dr. Castle's and Dr. Fino's opinions, regarding whether Claimant's COPD is a substantially contributing cause of Claimant's total disability, this Administrative Law Judge finds that these physicians' opinions have some probative value. In this case, while it is true that both Dr. Castle and Dr. Fino opined that Claimant does not have legal pneumoconiosis, both physicians based their opinions on a finding that Claimant's COPD is not due to coal mine dust rather than a finding that Claimant does not have COPD. Accordingly,

[67] Dr. Fino and Dr. Castle base their disability causation opinions in part on beliefs that are inconsistent with the regulations. Specifically, both physicians rely in part on the Claimant's tests which reveal that he had normal lung function for several years after he quit working as a coal miner. Yet the regulations recognize that pneumoconiosis, both clinical and legal, can be a latent and progressive disease that may first become detectible only after the cessation of coal mine dust exposure.

under these circumstances, the fact that Dr. Castle and Dr. Fino did not diagnose Claimant with legal pneumoconiosis does not affect their opinion of whether COPD was a substantially contributing cause of Claimant's disability. As a result, this Administrative Law Judge finds that the opinions of Dr. Castle and Dr. Fino are entitled to limited weight. It is noted that all of the physicians whose opinions are considered (Drs. Rasmussen, Robinette, Castle, and Fino), opined that Claimant's COPD/moderate obstructive lung disease is a contributing cause of Claimant's disability.

5. Conclusion

After deliberation on all the evidence of record, this Administrative Law Judge finds that the preponderance of the evidence demonstrates that Claimant has pneumoconiosis arising out of his coal mine employment and that Claimant is totally disabled due to that pneumoconiosis. In this case, Claimant established by a preponderance of the x-ray and medical opinion evidence, which is consistent with the other evidence of record, that he has pneumoconiosis arising out of his coal mine employment. Moreover, Claimant proved by a preponderance of the pulmonary function study, arterial blood-gas study, and medical opinion evidence that he is totally disabled. He further proved by a preponderance of the medical opinion evidence that his disability is due to pneumoconiosis. The Claimant has established a change in condition from the 2001 judicial denial as well as all the elements for entitlement to benefits under the current claim. Accordingly, the Claimant is therefore entitled to benefits under the Act.

VIII. Issue 8: Responsible Operator

Section 725.495(a)(1) states that the "operator responsible for the payment of benefits in a claim adjudicated under this part (the 'responsible operator') shall be the potentially liable operator, as determined in accordance with § 725.494, that most recently employed the miner." 20 C.F.R. § 725.495(a)(1). The burden to prove that the responsible operator, initially found liable for the payment of benefits, is a potentially liable operator is born by the Director. 20 C.F.R. § 725.495(b). In the absence of evidence to the contrary, the regulations state that it shall be presumed that the designated responsible operator is capable of assuming liability for the payment of benefits. 20 C.F.R. § 725.495(b).

The regulations define an operator as any owner, lessee, or other person who operates, controls, or supervises a mine; any independent contractor performing services or construction at a mine; any person who employs an individual in the transportation of coal or in coal mine construction at a mining site, to the extent such individual is exposed to coal mine dust as a result of such employment; any successor operator; or anyone who pays or provides benefits to an individual in exchange for working as a miner. 20 C.F.R. § 725.491.

Under Section 725.494, an operator may be considered a potentially liable operator if several conditions are met: (a) the miner's disability or death arose at least in part out of employment in or around a mine or other facility during a period when the mine or facility was operated by such operator or by a person with respect to which the operator may be considered a successor operator; (b) the operator, or any person with respect to which the operator may be considered a successor operator, was an operator of the mine after June 30, 1973; (c) the miner

was employed by the operator, or any person with respect to which the operator may be considered a successor operator, for a cumulative period of at least one year; (d) the miner was employed by the operator, or any person with respect to which the operator may be considered a successor operator, for at least one working day after December 31, 1969; and (e) the operator is capable of assuming liability for the payment of benefits. 20 C.F.R. § 725.494. For the purpose of determining whether an operator is a potentially liable operator, there is a rebuttable presumption that the miner's disability or death arose, in whole or in part, out of the miner's employment with the operator. 20 C.F.R. § 725.494(a).

Once an operator is designated as the responsible operator, that operator shall bear the burden of proving either:

> (1) That it does not possess sufficient assets to secure the payment of benefits … ; or,
>
> (2) That it is not the potentially liable operator that most recently employed the miner.
>
> Such proof must include evidence that the miner was employed as a miner after he or she stopped working for the designated responsible operator and that the person by whom he or she was employed is a potentially liable operator within the meaning of Sec. 725.494. In order to establish that a more recent employer is a potentially liable operator, the designated responsible operator must demonstrate that the more recent employer possesses sufficient assets to secure the payment of benefits in accordance with Sec. 725.606.

20 C.F.R. § 725.495(c). Moreover, the regulations provide that, once a case has been transferred to the Office of Administrative Law Judges for hearing, "documentary evidence pertaining to the liability of a potentially liable operator and/or the identification of a responsible operator which was not submitted to the district director shall not be admitted into the hearing record in the absence of extraordinary circumstances." 20 C.F.R. § 725.456(b)(1).

After reviewing all relevant evidence on the matter, this Administrative Law Judge finds that Employer is the properly designated responsible operator in this case. First, this Administrative Law Judge notes that the district director has satisfied his burden by proving that Employer is a potentially liable operator pursuant to the regulations. In naming Employer the designated responsible operator, the district director found that Employer, who is self-insured, is financially able to secure the payment of Claimant's benefits; was an operator of the mine after June 30, 1973; employed Claimant as a miner for a period of not less than one year; that Claimant worked for Employer for at least one working day after December 31, 1969; and that Employer is the operator that most recently employed Claimant. (DX 41.) The evidence of record supports the district director's findings.[68] (*See, e.g.*, DX 5, 7, 8, 28, and 43.) Thus, it is Employer's burden to prove either that it does not possess sufficient assets to secure the payment of Claimant's benefits or that it is not the potentially liable operator that most recently employed

[68] The only objection raised by Respondent Employer is that it was not the operator with whom Claimant was most recently employed for a cumulative period of at least one year. Respondent Employer argued that Claimant was employed as a coal miner subsequent to his employment with Employer. Yet there is no evidence of record substantiating this claim (DX 49; ALJX 3.)

the miner. In this case, there is no such evidence of either of the foregoing circumstances. Accordingly, as previously stated, this Administrative Law Judge finds that Employer is the properly designated responsible operator in this case.

Entitlement

Claimant is entitled to benefits beginning in the month he became totally disabled due to pneumoconiosis or, if such a date cannot be determined from the record, the month in which the miner filed his claim which, in this case, is August 2004. 20 C.F.R. § 725.503(b); *Owens v. Jewell Smokeless Coal Corp.*, 14 B.L.R. 1-47 (1990). Moreover, it is noteworthy that the date of the first medical evidence of record indicating total disability does not establish the onset date; rather, such evidence only indicates that the miner became totally disabled at some prior point in time. *Tobrey v. Director, OWCP*, 7 B.L.R. 1-407, 1-409 (1984).

Upon review of the record in this case, this Administrative Law Judge finds that the onset date cannot be determined from the medical evidence and, therefore, benefits are payable from August 2004, the month in which the miner's claim was filed. Moreover, as the parties have stipulated that Claimant has one dependent, his wife, Claimant is also entitled to augmentation of his award of benefits on behalf of his spouse.

SUMMARY OF FINDINGS AND CONCLUSIONS

After deliberation on all the evidence of record, this Administrative Law Judge finds that:

1. Claimant filed his application for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, (Act) in a timely manner on August 30, 2004;

2. Claimant is a miner as defined by the Act and worked for sixteen (16) years as a coal miner;

3. There has been a change in a condition of entitlement pursuant to 20 C.F.R. § 725.309(d) since Claimant's last claim was denied on June 15, 2001;

4. Claimant has pneumoconiosis as defined by the Act;

5. Claimant's pneumoconiosis arose out of his coal mine employment;

6. Claimant is totally disabled by a respiratory or pulmonary impairment as defined by the Act;

7. Claimant's total disability is due to pneumoconiosis;

8. Employer is the properly designated responsible operator in this case, and

9. Claimant is entitled to benefits payable from August 2004 and is entitled to have his award augmented on behalf of his one spousal dependent.

ORDER

IT IS ORDERED that the claim for benefits filed by the Claimant is hereby **GRANTED** and that payment of benefits shall commence as of August 1, 2004.

IT IS FURTHER ORDERED that, within thirty (30) days of the date of issuance of this Decision, Claimant's counsel shall file, with this Office, with a copy to opposing counsel, a petition for a representatives' fees and costs in accordance with the regulatory requirements set forth at 20 C.F.R. § 725.366. Counsel for the Director and for Employer shall file any objections with this Office, with a copy to Claimant's counsel, within (20) days of receipt of the petition for fees and costs.

A

ALAN L. BERGSTROM
Administrative Law Judge

ALB/MAM/jcb
Newport News, Virginia